Medical History

Patient Name: _____ **Date:** _____

PLEASE PRINT AS LEGIBLY AS POSSIBLE

Have you ever been hospitalized? If yes, please explain why and the year of hospitalization:

_____

List surgical procedures you have had and year of surgery:

_____

Significant prior accidents, injuries or trauma? Please explain including year of injury:

_____

Please list any ongoing illness or diseases (ex. Diabetes, Heart Disease, Cancer, etc.):

_____

Please list any allergies: _____

List all medications you are currently taking:_____

_____

Family History: Indicate if you have had any immediate family members with any of the following conditions. Please indicate Mother, Father, Sister, Brother.

□ Rheumatoid Arthritis: _____ □ Diabetes: _____ □ High Blood Pressure: _____

□ Heart Disease: _____ □ Stroke: _____ □ Cancer: _____ Other: _____

Social History:

Regular Exercise (please circle one): None / Light / Moderate / Strenuous

How many alcoholic beverages do you consume per week? _____

Do you use tobacco products? (please circle one) Past / Present / Never

Please list all tests you have had for your **current** complaint(s) (X-Ray, MRI, CT, Blood test, etc):

_____

Please list all supplements you are currently taking:

_____

Review of Systems – Please circle any symptoms below which you are experiencing

General- Lethargy (Extreme Tiredness) / Recurring Fever / Chills / Recent Weight Loss or Gain

HEENT- Headaches / Visual Changes / Nose Bleeds / Hearing Loss / Sore Throat / Hoarseness

Skin- Rashes / Mole Changes

Cardiovascular- Chest Pain / Shortness of Breath / Palpitations / Swelling of Hands or Feet / High Blood Pressure

Respiratory- Chronic or Frequent Cough / Spitting Up Blood / Asthma or Wheezing

Gastrointestinal- Nausea or Vomiting / Diarrhea / Abdominal Pain / Rectal Bleeding

Neurological- Dizziness / Fainting / Poor Balance / Numbness or Tingling / Limb Weakness

Musculoskeletal- Arthritis / Joint Pain / Neck Pain / Back Pain / Other Pain:_____

Blood/Lymph- Anemia / Bleeding / Bruising

Allergies- Seasonal / Other: _____

Psychiatric- Memory Loss or Confusion / Depression / Anxiety

Endocrine- Sweating / Heat Intolerance / Cold Intolerance / Excessive Thirst

Urinary- Frequent Urination / Burning or Painful Urination / Blood in Urine

Male / Female – Genital or reproductive organ problems: _____

Any other unusual symptoms not listed above: _____

Please list all other providers and treatments you have had for your **current** complaint(s) thus far:

_____

Please list any activities at home, at work, or in your social life that your complaint(s) are preventing you from doing, or preventing you from doing to the degree that you once could:

_____

Patient Signature : _____ Date : _____

Doctor Signature : _____ Date : _____