MEDICAL HISTORY FORM

Date _____ Chart #_____

Name _____

Birth Date _____ Age _____

Address _____

_____

Home Phone# _____

Work Phone # _____

Occupation _____

Employer _____

Height _____ Weight _____

Married _____ Single_____ Divorced _____

Separated _____ Widowed _____

Spouse's Name _____ Age _____

Children's _____ Age _____

Names _____ Age _____

_____ Age _____

_____ Age _____

OPERATIONS, INJURIES, OR HOSPITALIZATION	Date	Medical problems	Date

Medications now being taken, including over the counter products and birth control pills	Allergies and/or medication reactions (Penicillin, Sulfa, ect.)

IMMUNIZATIONS: (date of last shot/test)

Flu _____ Tetanus _____ Rubella _____

Tuberculin _____ Polio _____

Pneumonia _____ Hepatitis _____

FAMILY HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐
Breathing Problems	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Ulcer	☐	☐	☐	☐	☐	☐
Other - Specify _____	☐	☐	☐	☐	☐	☐

SYSTEMS REVIEW:Are you troubled with any of the following:

	YES	NO
Unexplained weight loss	☐	☐
Excessive Thirst	☐	☐
Excessive Fatigue	☐	☐

Skin and Hair

Any skin or hair problem	☐	☐

Nose & Throat

Eye Problem	☐	☐
Ear Problem	☐	☐
Nose Problem	☐	☐
Hoarseness	☐	☐
le Swallowing	☐	☐

Heart and Lungs

Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Coughing up Blood	☐	☐
Chest Pain	☐	☐
Wheezing	☐	☐
Chest Discomfort with Exercise	☐	☐
Irregular Heart Beat	☐	☐
Other Heart Trouble	☐	☐
Ankle Swelling	☐	☐
ay in Last Year	☐	☐
ou Ever had an EKG	☐	☐

Intestinal System

Weight Loss	☐	☐
Appetite Loss	☐	☐
Frequent Indigestion	☐	☐
Heartburn	☐	☐
Frequent Belching	☐	☐
Abdominal Pain	☐	☐

Intestinal System (Continued)

	YES	NO
Frequent Nausea & Vomiting	☐	☐
Change in Bowel Habits	☐	☐
Persistent Constipation	☐	☐
Frequent Diarrhea	☐	☐
Rectal Bleeding	☐	☐
Rectal Itching or Soreness	☐	☐

Urinary System

Painful Urination	☐	☐
Passing Blood	☐	☐
Poor Bladder Control	☐	☐
Weak Stream	☐	☐
Urination more than once a night	☐	☐

Skeleton and Joints

Pain in Joints	☐	☐
Swelling in Joints	☐	☐

Back Trouble	☐	☐

Nervous System

Severe Headaches	☐	☐
Numbness of Hands & Feet	☐	☐
UncontrollableTension	☐	☐
Increased Irritability	☐	☐
Feelings of Being “Blue”	☐	☐
Suicidal Thoughts	☐	☐

Personal Problems (health, family and business)

Problems with Sexual Relations	☐	☐
Have you had Psychiatric Help	☐	☐
Do you desire Psychiatric Help	☐	☐

	YES	NO	***If Yes, Average Amount***
	☐	☐	_____
Beer	☐	☐	_____
Wine	☐	☐	_____
Coffee	☐	☐	_____
Mixed Drinks	☐	☐	_____

Do You Smoke? YES NO

If so, how much _____(Packs per Day)

For how long? _____

Do you use or ever used drugs? (marijuana, cocaine, opiates, LSD, other)

OMEN ONLY

	YES	NO
Have you ever had an abnormal Pap Smear?	☐	☐
Are your periods irregular?	☐	☐
Do you bleed between periods?	☐	☐
Do you take birth control pills?	☐	☐
Do you have an IUD?	☐	☐
When was your last period? _____	☐	☐

How long is it between periods? _____

How many days do you flow? _____

Amount: Small _____ Moderate _____ Heavy_____

When was last Pap Smear? _____

No. of Pregnancies _____

No. of Living Children _____

No. of Miscarriages _____

No. of Abortions _____

Last Mammogram _____

FOR MEN ONLY

	YES	NO
Have you had any of the following:		
Sore on penis?	☐	☐
Discharge from penis?	☐	☐
Swelling or tenderness of scrotum?	☐	☐
Any problems with sex function?	☐	☐
Any problems having children?	☐	☐
Prostate trouble?	☐	☐
Have you had a Vasectomy?	☐	☐
Have you ever had an instrument passed into the bladder?	☐	☐