MEDICAL HISTORY

Name _____ Today's Date _____

Age _____ Referred by _____

Previous surgeries (with dates) _____

_____

_____

Other hospitalizations _____

_____

Your medications (including aspirin) _____

_____

_____

Allergies to medications (What is the reaction?) _____

_____

Does anyone in your family have (circle): ☐ cancer ☐ heart disease ☐ diabetes ☐ High blood pressure

Any other medical condition? _____

Do you drink alcohol? If so, how much? _____

Do you smoke? If so, how much? _____

Local medical doctor _____

Have you ever had (circle):

Heart problems	☐ angina	☐ valve disease	☐ rheumatic fever	☐ heart attack	☐ high blood pressure
Lung problems	☐ asthma	☐ emphysema	☐ bronchitis	☐ collapsed lung	☐ chronic cough
Blood problems	☐ anemia	☐ bleeding tendency	☐ transfusion	☐ easy bruisability	
Endocrine	☐ diabetes	☐ thyroid disease			
Other	☐ head injury	☐ seizures	☐ liver trouble	☐ hepatitis	☐ ulcer
	☐ constipation	☐ arthritis	☐ tuberculosis	☐ difficulty hearing	☐ kidney problems
Eyes	☐ glasses	☐ contact lenses	☐ cataract surgery		

Any other medical condition not listed _____

WOMEN: ☐ pregnant ☐ tubal ligation ☐ post menopausal ☐ use oral contraceptives

Number of children and ages _____

Height _____ Weight _____

For office use: VS _____ BP _____ P _____ R _____ T _____

Chief complaint