

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 _____