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MEDICAL HISTORY FORM

DATE: ____/_____/_____ REASON FOR VISIT_________________________________

Name: (*First, Last, MI)*		☐ M ☐ F	Age:
DATE OF BIRTH:	☐ Married ☐ Single ☐ Divorced ☐ Widowed		

PERSONAL HEALTH HISTORY	
CURRENT MEDICATIONS (Name, Strength, Frequency):	☐ **NONE**

HOSPITALIZATIONS/SURGERIES		☐ **NONE**
Year	**Reason**	**Hospital**

Have you ever had any of the following? (Please check all that apply)		☐ **NONE**
☐ Heart Attack	☐ High Blood Pressure	☐ Diabetes
☐ Stroke	☐ Epilepsy	☐ Cancer
☐ HIV/AIDS	☐ Hepatitis	☐ Ulcers
☐ Kidney Disease	☐ Bleeding Disorder	☐ Thyroid Disease
☐ Lung Disease (Asthma, TB, Pneumonia, Emphysema)		☐ Psychiatric Disorder (e.g. Anxiety, Depression)
List any other medical problems:		
Any Injuries:		

REVIEW OF SYSTEMS
Do you currently have any of the following:

General	Ear/Nose/Throat	Gastrointestinal	Musculoskeletal	Psychiatric
□ Chills	□ Bleeding gums	□ Abdominal pain	□ Joint Pain	□ Anxiety
□ Fever	□ Difficulty hearing	□ Constipation	□ Joint Redness	□ Depression
□ Fatigue	□ Difficulty speaking	□ Diarrhea	□ Joint Stiffness	□ History of Alcohol Dependence
□ Loss of Appetite	□ Difficulty swallowing	□ Heartburn	□ Joint Swelling	□ History of Drug Dependence
□ Recent weight loss	□ Ringing in your ears	□ Nausea	□ Muscle Pain	**Endocrine**
□ Recent weight gain	□ Frequent colds	□ Dark black stools; blood in stools	□ Muscle Cramping	□ Excessive thirst
□ Trouble sleeping	□ Sore throats	□ Ulcers	**Neurological**	□ Hypoglycemia (Low Blood Sugar)
Eyes	□ Hoarseness	□ Recent change in bowel habits	□ Numbness	**Hematological/Immunologic**
□ Blurred vision	□ Earaches	□ Rectal bleeding	□ Tingling	□ Swollen lymph nodes
□ Tearing	□ Nose bleeds	□ Vomiting	□ Seizures	□ Easy bruising
□ Redness	**Cardiovascular**	**Genitourinary**	□ Headache	□ Anemia
□ Itching	□ Chest pain	□ Burning on urination	□ Loss of Memory	□ Blood clots
□ Light sensitivity	□ Palpitations	□ Frequent urination	□ Vertigo (Dizziness)	**Respiratory**
Skin/Breast	□ Swelling of feet/ankles	□ Frequent urinary tract infections	□ Tremors	□ Chronic cough/sputum production
□ Rash	□ Murmur	□ Vaginal discharge	□ Hands falling asleep	□ Wheezing
□ Breast Lump	□ Leg Cramps	□ Urethral discharge		□ Shortness of breath with exertion
□ Bruises		□ Changes in urinary stream		□ Shortness of breath with rest

SOCIAL HISTORY

Alcohol	Do you drink alcohol?		□ Yes □ No
	If yes, how many drinks per week?		
Tobacco	Do you currently use tobacco?		□ Yes □ No
	How many years?	How many packs per day?	
	Chew # per day	Pipe # per day	Cigars # per day
	If you previously smoked, when did you quit?		
	How many packs did you smoke per day?		
	How many years did you smoke?		
Drugs	Do you currently use recreational or street drugs		□ Yes □ No

OCCUPATIONAL HISTORY

Current Occupation:

How many years:

If unemployed, when did you last work:

I state that I have answered the questionnaire with information that is true and correct and to the best of my ability.

________________________ Signature

________________________ Date