Medical History Form

Name ____

Reason for Consultation ____

Referring Physician ____________________________Primary Care Physician______________________

Past Medical History

Check all that apply and list details/diagnoses

□ Heart Attack/Heart Disease □ Congestive Heart Failure □ Diabetes □ High Blood Pressure □ Emphysema

□ COPD □ Thyroid Problems □ Asthma □ Stroke □ Heart Failure □ Hepatitis B □ Hepatitis C □ AIDS/HIV

□ Coagulation or Bleeding Disorder (you may take Plavix or Coumadin for)

□ Sleep Apnea □ Cancer ____

Other Medical Problems and Details:

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SURGICAL HISTORY: Including Defibrillators, Pacemakers, or Stents

Operation	Date	Operation	Date

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, aspirin or blood thinners.

Medication	Dose	Times per Day	Medication	Dose	Times Per Day

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ALLERGIES or REACTIONS: □ None □ Latex

Medication	Reaction or Side Effect

FAMILY HISTORY:

Please check all that apply.

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other
Anesthesia Problem							
Asthma							
Bleeding Problem							
Breast Cancer							
Colon Cancer							
Melanoma							
Thyroid Cancer							
Parathyroid Cancer							
Prostate Cancer							
Diabetes							
Heart Attack							
High Blood Pressure							
Kidney Disease							
Leukemia							
Lupus							
Lymphoma							
Stroke							
Vascular Disease							
Living							
Deceased							

SOCIAL HISTORY

Tobacco Use

Cigarettes: □ Never □ Current Smoker: Packs/day______ # of Years _________

□ Quit: Date ______________ How many years did you smoke? ______________

Other Tobacco:

□ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use

□ No □ Yes: # of Drinks/Week __________________

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Is your current Illness/problem work related? ____yes ____no

Please Indicate Below If You Are Currently Experiencing Any of These Symptoms:

General, Constitutional			**Musculoskeletal**		
Does your job require heavy lifting	no	yes	Joint Pain	no	yes
Recent Weight Gain	no	yes	Back Pain	no	yes
Recent Weight Loss	no	yes	Muscle Pain or Cramps	no	yes
Fever	no	yes	Difficulty in Walking	no	yes
Fatigue	no	yes			
			Skin and Breasts		
Eyes and Vision			Change in Skin Color	no	yes
Wear Glasses or Contact Lenses	no	yes	Varicose Veins	no	yes
			Rash or itching	no	yes
Ears, Nose, Throat			Healing Problems	no	yes
Swollen Lymph Nodes	no	yes			
Trouble Swallowing	no	yes	**Neurological**		
			Frequent Headaches	no	yes
Heart and Cardiovascular			Light Headed or Dizzy	no	yes
Shortness of Breath with activity or exertion	no	yes	Seizures	no	yes
Chest Pains	no	yes	Tremors	no	yes
Sudden Heartbeat Changes/Irregular Heartbeat/Palpitations	no	yes			
Swelling of Feet, Ankles, Hands	no	yes	**Psychiatric**		
Murmurs	no	yes	Memory Loss or Confusion	no	yes
			Nervousness/Anxiety	no	yes
Respiratory			Depression	no	yes
Persistent/Frequent Coughing	no	yes			
Shortness of Breath	no	yes	**Endocrine**		
Asthma or Wheezing	no	yes	Excessive Thirst	no	yes
			Excessive Urination	no	yes
Gastrointestinal					
Loss of Appetite	no	yes	**Genitourinary**		
Change in Bowel Movements	no	yes	Frequent Urination	no	yes
Nausea or Vomiting	no	yes	Difficulty with Urination	no	yes
Frequent Diarrhea	no	yes	Blood in Urine	no	yes
Painful Bowel Movements or Constipation	no	yes	Change in Force or Strain with Urination	no	yes
Blood in Stool	no	yes	Recurrent UTI	no	yes
Abdominal/Stomach Pain	no	yes			
Difficulty Swallowing	no	yes	**Hematological/Lymphatic**		
Heartburn	no	yes	Slow to Heal After Cuts	no	yes
Hemorrhoids	no	yes	Easily Bruise or Bleed	no	yes
Rectal Bleeding	no	yes	Anemia	no	yes

Patient Signature: ____ Date: ____________________

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