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MEDICAL HISTORY

(Please Complete all four pages)

Date: _____

Name: _____

Age: _____ Height: _____ Weight: _____

Referring physician: _____

Address: _____

Family physician: _____

Address: _____

May we correspond with these physicians regarding your care? _____

Who referred you to this office? _____

May we thank this person for your referral? _____

What is the purpose of this consultation? _____

How long has this problem been present? _____

PAST MEDICAL HISTORY

ILLNESSES: (List any illnesses that requires medical attention)

HOSPITALIZATIONS: (Include date, place, reason, doctor)

OPERATIONS: (Include date)

INJURIES:

ALLERGIES: (history of skin reaction or adverse reaction to)

- | | | |
|---|------------------------------|-----------------------------|
| Penicillin or other antibiotic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Morphine, Demerol or other narcotic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lidocaine or other anesthetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aspirin or other pain remedies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tetanus antitoxin or other serums | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Iodine, methiolate or other antiseptics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

OTHER DRUGS/MEDICATIONS/ALLERGIES:

Known food allergies _____

MEDICATIONS: (List the medications you are now taking)

MEDICATION	DOSAGE	FREQUENCY	PURPOSE
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SOCIAL HISTORY

Birth place: _____

Where was childhood spent? _____

Marital status: single married divorced widow(er) _____

Occupation: _____

Education: (number of years) _____ Location: _____

HABITS: Tobacco (amount & how long) _____

Alcohol type and amount used) _____

Have you ever used drugs for recreational purposes? Yes No

Explain: _____

FAMILY HISTORY

List any medical problems that run in your family (bleeding tendencies, anesthetic problems, etc.)

RELATIVES

AGE

STATE OF HEALTH

Father _____

Mother _____

Spouse _____

Brothers _____

Sisters _____

Sons _____

Daughters _____

REVIEW OF SYSTEMS:

(Check the appropriate answers and fill in the blanks where necessary)

GENERAL:

State of health: Excellent Good Fair Poor
Recent change in weight: Gain Loss How much? _____

EYES, EARS, NOSE AND THROAT

Problem with: Eye Ear Nose Throat Sinuses No Problems
Explain: _____

RESPIRATORY:

Shortness of breath, mucous production, cough up blood, wheezing, asthma. No problems
Explain: _____

HEART:

Chest pains, high blood pressure, ankle swelling, awake at night, short of breath, shortness of breath when lying down. No problems
Explain: _____

GASTROINTESTINAL:

Abdominal pain, change in bowel habits recently, black stool, blood in stool, hemorrhoids, nausea, vomiting, history of jaundice or hepatitis. No problems
Explain: _____

GENITOURINARY:

Kidney or bladder problems, trouble urinating (burning, dribbling) No problems
Age at onset of periods Periods irregular?
Any female disorders? Yes No
Explain: _____

MUSCULOSKELETAL:

Bone or joint trouble? No problems
Dominant hand: Right Left

NERVOUS SYSTEM:

Seizures, fainting, headaches, dizziness, double vision, significant depression. No problems
Explain: _____

ENDOCRINE SYSTEMS:

Diabetes, thyroid disease. No problems
Explain: _____

HEMATOPOETIC SYSTEM:

Anemia, bruise easily, bleeding tendencies. No problems
Explain: _____

Reviewed on: _____

By: _____