MEDICAL HISTORY

PATIENT NAME:____ DOB:________________TODAY'S DATE:____________

REASON FOR TODAY'S VISIT____

PREVIOUS TREATMENT FOR THIS PROBLEM____

ALL SURGERIES	DATE OF SURGERY	DRUG ALLERGIES	☐ NONE
____________________	_____________________	______________________	________________________
____________________	_____________________	______________________	________________________
____________________	_____________________	______________________	________________________
____________________	_____________________	______________________	________________________

ALL MAJOR MEDICAL PROBLEMS	CURRENT MEDICATIONS AND DOSES	
______________________________________	______________________	________________________
______________________________________	______________________	________________________
______________________________________	______________________	________________________
______________________________________	______________________	________________________
______________________________________	______________________	________________________

DO YOU TAKE ASPIRIN? YES ___ NO ___ DAILY _____ CAFFEINE USE: NO _____ YES______ HOW MUCH____________

TOBACCO USE (CIRCLE ONE) NO QUIT _____ yrs/mos ago YES ______ packs per day for _______ years

ALCOHOL USE (CIRCLE ONE) Never Rarely Once per week Weekends ___________ drinks per day ________Other _____

FAMILY MEDICAL HISTORY

Mother: Alive Died age _____ Significant Medical Problems ____

Father: Alive Died age _____ Significant Medical Problems ____

Siblings: ____# sisters & ______# brothers Significant Medical Problems ____

Children: ____#girls & ______# boys Significant Medical Problems ____

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

(Y)	(N)		(Y)	(N)		(Y)	(N)	
____	____	High Blood Pressure	____	____	Stomach pain	____	____	Anemia
____	____	Cancer	____	____	Cholesterol issues	____	____	Heart attack/surgery/disease
____	____	Difficulty walking	____	____	Hepatitis/liver disease			
____	____	Intestine/colon issues	____	____	Kidney disease			
____	____	Fainting episodes	____	____	Asthma			
____	____	Stroke/numbness	____	____	HIV/TB			

ARE YOU CURRENTY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

(Y)	(N)		(Y)	(N)		(Y)	(N)	
____	____	Blurry vision	____	____	Coughing	____	____	Anxiety
____	____	Hearing Loss	____	____	Heartburn	____	____	Trouble sleeping
____	____	Sinus issues	____	____	Difficulty Swallowing	____	____	Depression
____	____	Sore Throat	____	____	painful urination	____	____	Thyroid problems
____	____	Ringing in ears/tinnitus	____	____	Kidney stones	____	____	Fatigue
____	____	Hoarseness	____	____	Bone or joint pain	____	____	Diabetes
____	____	Chest Pain	____	____	Muscle weakness	____	____	Easy bruising
____	____	Irregular heartbeat	____	____	rashes	____	____	Easy Bleeding
____	____	Shortness of Breath	____	____	Chronic sores	____	____	allergies
____	____	Snoring	____	____	facial weakness	____	____	Fever /chills/night sweats
			____	____	Dizziness	____	____	Unexpected weight loss