

Welcome to our practice. Please fill out the information found below to the best of your ability.

Physician: _____

Date: _____

Patient Name: _____

Date of Birth: _____

Age: _____

Medical History:

• Patient Medical History

Diabetes	No	Yes	Previous Hospitalization/Surgeries/Serious/Injuries:	When
Hypertension	No	Yes	_____	_____
Cancer	No	Yes	_____	_____
Stroke	No	Yes	_____	_____
Heart Trouble	No	Yes	_____	_____
Arthritis/Gout	No	Yes	Medications:	
Convulsions	No	Yes	_____	_____
Bleeding Tendency	No	Yes	_____	_____
Acute Infections	No	Yes	_____	_____
Venereal Disease	No	Yes	_____	_____
Hereditary defects	No	Yes	_____	_____

• Patient Social History

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Previously, but quit: _____ Current Packs/Day: _____
Use of Drugs: Never: _____ Type/Frequency: _____
Excessive exposure at _____ Air-borne
Home or work to: Fumes: _____ Dust: _____ Solvents: _____ Particles: _____ Noise: _____

• Family Medical History

	Age	Diseases	If Deceased, Cause
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Reviewed by: _____

Date: _____

Notes: _____

Reviewed by: _____

Date: _____

Notes: _____

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Date: _____

Notes: _____

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Date: _____

Notes: _____

Review of Systems: Please indicate any personal history below.

• **CONSTITUTIONAL SYMPTOMS**

Good general health lately..... No Yes
 Recent Weight Change..... No Yes
 Fever..... No Yes
 Headaches..... No Yes

• **EYES**

Eye disease or injury..... No Yes
 Wear Glasses/Contact Lenses..... No Yes
 Blurred or Double Vision..... No Yes
 Glaucoma..... No Yes

• **EARS/NOSE/MOOUTH/THROAT**

Hearing loss or ringing..... No Yes
 Earaches or drainage..... No Yes
 Chronic sinus problem or rhinitis..... No Yes
 Nose bleeds..... No Yes
 Mouth Sores..... No Yes
 Bleeding Gums..... No Yes
 Bad Breath or Bad Taste..... No Yes
 Sore Throat or Voice Change..... No Yes
 Swollen Glands in Neck..... No Yes

• **CARDIOVASCULAR**

Heart Trouble..... No Yes
 Chest pain or angina pectoris..... No Yes
 Palpitation..... No Yes
 Short of breath with walking/lying flat..... No Yes
 Swelling of feet, ankles, or hands..... No Yes

• **RESPIRATORY**

Chronic or frequent coughs..... No Yes
 Spitting up Blood..... No Yes
 Shortness of Breath..... No Yes
 Asthma or Wheezing..... No Yes

• **GASTROINTESTINAL**

Loss of appetite..... No Yes
 Change in bowel movements..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Painful bowel movements or constipation..... No Yes
 Rectal bleeding or blood in stool..... No Yes
 Abdominal pain..... No Yes
 Peptic ulcer (stomach or duodenal)..... No Yes

• **GENITOURINARY**

Frequent Urination..... No Yes
 Burning or painful Urination..... No Yes
 Blood in Urine..... No Yes
 Change in force of strain when urinating... No Yes
 Incontinence or dribbling..... No Yes
 Kidney Stones..... No Yes
 Sexual difficulty..... No Yes
 Male – testicle pain..... No Yes
 Female – pain with periods..... No Yes
 Female – irregular periods..... No Yes
 Female – vaginal discharge..... No Yes
 Female – # of pregnancies..... _____
 Female – # of miscarriages..... _____
 Female – date of last pap smear..... _____

• **MUSCULOSKELETAL**

Joint Pain..... No Yes
 Joint Stiffness or swelling..... No Yes
 Weakness of muscles or joints..... No Yes
 Muscle Pain or Cramps..... No Yes
 Back Pain..... No Yes
 Cold extremities..... No Yes
 Difficulty in walking..... No Yes

• **INTEGUMENTARY (skin, breast)**

Rash or itching..... No Yes
 Change in skin color..... No Yes
 Change in hair or nails..... No Yes
 Varicose Veins..... No Yes
 Breast Pain..... No Yes
 Breast Lump..... No Yes
 Breast Discharge..... No Yes

• **NEUROLOGICAL**

Frequent or recurring headaches..... No Yes
 Light headed or dizzy..... No Yes
 Convulsions or seizures..... No Yes
 Numbness or tingling sensations..... No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head Injury..... No Yes

• **PSYCHIATRIC**

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Insomnia..... No Yes

• **ENDOCRINE**

Glandular or hormone problem..... No Yes
 Thyroid Disease..... No Yes
 Diabetes (insulin or non insulin – circle one) No Yes
 Excessive thirst with urination..... No Yes
 Heat or cold intolerance No Yes
 Skin becoming drier..... No Yes
 Change in hat or glove size..... No Yes

• **HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts..... No Yes
 Bleeding or bruising tendency..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

• **ALLERGIC/IMMUNOLOGY**

History of skin reaction or other reaction to: No Yes
 Penicillin or other antibiotic..... No Yes
 Morphine, Demerol, or other narcotics..... No Yes
 Novocain or other anesthetics..... No Yes
 Aspirin or other pain remedies..... No Yes
 Tetanus antitoxin or other serums..... No Yes
 Iodine, methiolate or other antiseptic..... No Yes
 Other drugs/medicines: _____
 Know food Allergies: _____
 Environmental Allergies: _____

Reviewed by: _____ Date: _____