MEDICAL HISTORY INFORMATION SHEET

NAME: _____ AGE:_____ TODAY'S DATE: ____/____/_____

Birth Date: (M / D / Year) _____/_____/_____ Height ____ft____inches Weight _____lbs

REASON FOR TODAY'S EXAM _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

High Blood Pressure	DVT	Lung Disease	Stroke
High Cholesterol	Pulmonary Embolus	Asthma	Diabetes
Vein Trouble	Tuberculosis	Heart Trouble	Pneumonia
Kidney Disease	Nervous Disorder	Seasonal Allergies	HIV
Thyroid Problems	Sinus	Arthritis	Hepatitis
Drug Abuse/Alcoholism	Tonsillitis	Gastrointestinal	Osteoporosis
Joint Replacement	Bleeding Tendencies	Cancer:	If Yes, What Type _____

Other: _____

History of Serious Injuries / Illnesses? YES NO If yes, please describe below.

_____

SURGICAL HISTORY and/or SURGICAL COMPLICATIONS? Please list

_____

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

High Blood Pressure _____	DVT _____	Lung Disease _____	Stroke _____
High Cholesterol _____	Pulmonary Embolus _____	Asthma _____	Diabetes _____
Vein Trouble _____	Tuberculosis _____	Heart Trouble _____	Pneumonia _____
Kidney Disease _____	Nervous Disorder _____	Seasonal Allergies _____	HIV _____
Liver Disease _____	Seizures _____	Ear Problems _____	Sinus _____
Drug Abuse / Alcoholism _____	Thyroid Problems _____	Arthritis _____	Tonsillitis _____
Joint Replacement _____	Hepatitis _____	Gastrointestinal _____	Osteoporosis _____
Cancer: Type _____	Bleeding Tendencies _____		

Other: _____

SOCIAL HISTORY:

Occupation: _____ Marital Status:_____ Children: Yes No Live Alone: Yes No

Tobacco Use: Never In the Past Presently How Much? _____ How Long? _____

Alcohol Use: Daily Occasional None Other substance use or abuse? Yes No

SYSTEM REVIEW: Please describe any active problem or symptom.

General Symptoms (i.e. fever, weight gain/loss, fatigue) _____

Eyes/Ears/Nose/Throat _____	Heart _____	Lung _____
Allergies/Rashes _____	Muscles/Bones/Joints _____	Psychiatric _____
Endocrine (Diabetes/Thyroid) _____	Bleeding/Lymph Nodes _____	Nerves _____
Skin and/or Breasts _____	OB/Genital/Urinary _____	Abdomen _____

ALLERGIC TO: <u>LATEX:</u> Yes No <u>MEDICATIONS:</u> Yes No <u>METAL:</u> Yes No

PLEASE LIST ALLERGIES:_____

CURRENT MEDICATIONS:_____

_____