MEDICAL HISTORY

NAME: _____
REFERRED BY: _____
AGE: _____DOB: _____
HEIGHT: _____WEIGHT: _____
REASON FOR SEEING THE DOCTOR:

_____

_____

_____

Do you have any of the following?

Cardiovascular	**Yes**	**No**	**Head, Eyes, Ears, Nose, Throat**	**Yes**	**No**
Chest Pain			Unusual or severe headaches		
Easily fatigued by exercise			Migraines		
Irregular heart beats			Dizziness, Lightheadedness		
Palpations			Loss of consciousness		
Atrial Fibrillation			Recent vision changes (not correctable)		
Ankle Swelling			Head injury in the past		
Need to urinate after bedtime			Seizures		
Sleep on more than one pillow (to facilitate breathing)			**Respiratory:**		
Aching in legs when walking			Shortness of breath with:		
Angina			a. Activity		
High Blood Pressure			b. Minimal exertion		
Diabetes			c. At rest		
Arteriosclerosis (hardening of arteries)			d. At night		
Rheumatic fever			e. Lying down flat		
Heart Murmur			Abnormal chest X-ray		
Heart Attack			Frequent colds		
Congestive Heart Failure			Frequent or prolonged cough		
Enlarged Heart			Cough up blood		
Abnormal EKG			Respiratory Disease (asthma, emphysema, bronchitis, etc.)		
Chest Injury			Use breathing medications		
Elevated Cholesterol			Pneumonia		
Other Lipid (fat) abnormality			Blood clot to lung		
Treat for cholesterol/lipid			Tuberculosis		
			Sleep Apnea		
			Snore		

MEDICAL HISTORY CONT.

Emotion	Yes	No	Urinary	Yes	No
Mood changes			Kidney infection		
Memory loss			Kidney stone		
Difficulty with speech			Incontinence		
Nervousness			Unusual pattern of urination		
Anxiety			Blood in urine		
Depression			Urgency		
Restless Leg Syndrome			Urine color change		
Gastrointestinal			Prostate problems		
Jaundice					
Hepatitis			**Extremities, Bones, and Joints**		
Recent nausea or vomiting			Coldness		
Stomach or duodenal ulcer			Deformities		
Recent change in bowel habits			Discoloration		
Problems with constipation			Swelling or edema		
Stools ever black in color			Hair loss		
Bright red blood in stools			Pain		
Hemorrhoids			Cramping		
Gallbladder disease			Weakness		
Diarrhea			Bones and joints		
Diverticulitis			a. Stiffness		
Barrett's Esophagitis			b. Swelling		
Endocrine			c. Redness		
Thyroid			d. Limitation of movement		
Diabetes			e. Fractures		
Hypoglycemia			f. Back pain		
Goiter, thyroid cysts or mass			Circulation problems in arms or legs		
Hormone Therapy			Take arthritis medication		
Frequent urination					
Frequent thirst					
Gout					

PERSONAL HABITS:

SMOKING: Did you ever smoke? _____ Packs per day _____
Do you smoke now? _____ Year you quit _____

DRINKING: Current drinks per week _____
Ever more than that previously _____

EXERCISE: Currently on an exercise program _____
Occupation sedentary _____

DIET RESTRICTIONS:

STRESS:

Occupational: _____
Personal-family etc. _____
Recent major life change _____

MEDICAL:

Regular check-up _____
If female- regular exams _____

CARDIOPULMONARY RESUSCITATION:

Do you know Cardiopulmonary Resuscitation (CPR)? _____
Do other members of your family know CPR? _____
Would you or your family be interested in learning how to do CPR? _____

Below, please describe all previous hospitalizations or medical conditions that have been diagnosed and list any previous surgeries:

DATE	HOSPITAL	DOCTOR	DIAGNOSIS	OPERATION
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PLEASE LIST ALL CURRENT MEDICATIONS (including over-the- counter medicines and vitamins)

DRUG	DOSE	FREQUENCY	DATE STARTED(YR)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES:

DRUG: _____

_____

_____

FOOD: _____

_____

_____

ENVIRONMENTAL: _____

_____

_____

Family History:

	Heart Disease	Stroke	Diabetes	Hypertension	Lung Disease	Cancer	Smoke	Other
Father's Father								
Father's Mother								
Mother's Father								
Mother's Mother								
Uncles								
Aunts								
Father								
Mother								
Sisters								
Brothers								
Sons								
Daughters								