Medical History

Name:____________________________ D.O.B.____________ Today's Date:___________

Height_______ Weight_______ Temperature____ Blood Pressure____ Pulse____ Respirations____

Medications including dosage:

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Allergies: Please circle any medications to which you are allergic:

Penicillin Sulfa Codeine Morphine Demerol Aspirin Adhesive tape Tetanus Horse serum Anti-inflammatories None Other: ____

Habits: Smoking: Yes Not Currently Never Packs per day____ Number of years______

Use of alcohol: Yes No Daily: Yes No

Today's Problem list:

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Surgery:

Please list the type of surgery and date

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Hospitalizations:

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Family history:

Please circle all that apply and indicate the relationship

Cancer______ Heart Attack______ Mental illness________ Diabetes______ Stroke______ Other______

Social history:

Occupation___________ Married or Single (circle one) Number of Children____________

Do your live alone or with someone?______________________

Review of systems:

ENT: Glaucoma_______ Tumor_______ Other_______________

Respiratory: Pneumonia_____ COPD______ Asthma________ Hay Fever______ Other_______

Cardiovascular: Heart attack___ Peripheral Vascular Disease____ Varicose Veins______ Phlebitis__ _

Angina____ Palpitations____ Congestive Heart Failure____ Atrial Fibrillation_____ Other_________

Gastro Intestinal: Ulcers___ Diverticulosis____ Hiatal Hernia_____ Hemorrhoids____ Hepatitis____

Gallbladder Trouble_____ Colitis_____ Appendicitis_____ Other__________

Genitourinary: Kidney Stones______ Frequent Bladder Infections_____ Kidney Infections_____

Prostate problems______ other__________

Musculoskeletal: Gout___ Rheumatoid Arthritis____ Lupus_____ Ankylosing Spondylitis_____

Fractures_________ Other________________

Neurological: Concussion_____ Neuropathy____ Sciatica______ Meningitis____ Polio_____

Seizures______ Stroke_____ Other________

Endocrine: Diabetes_________ Thyroid disease_____ Other Endocrine Disease___________

Psychiatric: Mental illness__________ Nervous Breakdown________ Other__________

OB/GYN: Painful periods_______ Ectopic pregnancy______ abortion______ miscarriage_______

PID______ C-Section________ Age of Menopause______ Currently Pregnant?_______

Date of last pelvic exam_________ Other______________

Signature of Patient or Legal Guardian:_________________________________ Date: ___/___/_____