Medical History

Name _____ Last 4 Digits of SS# _____ Date of Birth _____

CONSTITUTIONAL SYMPTOMS
Good general health lately ..... No Yes
Recent weight change ..... No Yes
Fever ..... No Yes
Fatigue ..... No Yes
Headaches ..... No Yes
Night Sweats ..... No Yes

EYES
Blurred or double vision ..... No Yes
Glaucoma ..... No Yes

EARS/NOSE /MOUTH/THROAT
Hearing loss or ringing ..... No Yes
Nose bleeds ..... No Yes
Mouth sores ..... No Yes
Bleeding gums ..... No Yes
Sore throat or voice change ..... No Yes
Swollen glands in neck ..... No Yes

CARDIOVASCULAR
Heart trouble ..... No Yes
Chest pain ..... No Yes
Palpitation ..... No Yes
Shortness of breath with walking or 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
Male - testicle pain ..... No Yes
Female - menopausal or pre-menopausal ..... No Yes
Female - # of miscarriages .....

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
Soft / peeling nails ..... 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
Balance issues ..... No Yes
Tremors ..... No Yes
Paralysis ..... No Yes
Stroke ..... 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 or urination ..... No Yes
Heat or cold intolerance ..... No Yes
Skin becoming dryer ..... No Yes
Change in hat or glove size ..... No Yes

HEMATOLOGIC/LYMPHATIC
Bleeding or bruising tendency ..... No Yes
Anemia ..... No Yes
Phlebitis ..... No Yes
Past transfusion ..... No Yes
Enlarged glands ..... No Yes
Bleeding with surgery ..... No Yes

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics ..... 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/medications: .....
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List **past medical problems**:_____

List **medications** you are taking: _____

Do you **smoke**? No How much:_____ Do you **drink**? No How much:_____

Do you get **exercise**? What kinds and how much:_____

List any **family history of medical problems**: _____

Physician review		Physician review		Physician review	
Confirmed_____	Date_____	Confirmed_____	Date_____	Confirmed_____	Date_____
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