

**PATIENT MEDICAL HISTORY**

**TODAY'S DATE:** \_\_\_\_\_ Acct: \_\_\_\_\_ Page 1/2

It is important for your doctor to know you have carefully reviewed every area of this form. Please fill out every item. This information will be entered into your electronic medical record.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Gender: M / F Date of Birth: \_\_\_\_\_ Marital status: \_\_\_\_\_

Most recent occupation: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

Approximate date of onset: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Who is your Primary Care Provider? \_\_\_\_\_

**Pharmacy/address/phone:** \_\_\_\_\_

Please list all the medications (prescription & non-prescription) that you are currently taking:

<b>Medication</b>	<b>Dose</b>	<b>Reason for taking this medication</b>

**Are you allergic to any medication? YES / NO If Yes, please list all medication allergies and the type of reaction:**

\_\_\_\_\_

Any other allergies? \_\_\_\_\_ Have you had allergy testing? YES / NO

**Past Medical History**

Do you have any of the following? YES / NO Please circle the appropriate medical condition(s).

- a) Diabetes, hypoglycemia
- b) High cholesterol
- c) High blood pressure
- d) Liver disease, jaundice
- e) Hepatitis
- f) History of tuberculosis
- g) History of kidney stones
- h) Thyroid problems
- i) Bleeding or bruising problems
- j) History of stomach or duodenal ulcer
- k) History of cancer, type \_\_\_\_\_
- l) Depression, anxiety, "panic attacks"
- m) Environmental allergies
- n) Blood-borne disease that you would like to reveal to the doctor?

Other medical conditions or problems: \_\_\_\_\_

Have you or anyone in your family been seen by one of our physicians in the past? YES/NO

If yes, please remind us of that person's name and the physician he or she saw. \_\_\_\_\_

**Review of Systems**

**Patient Name** \_\_\_\_\_ **Acct:** \_\_\_\_\_

Do you have any of the following? YES / NO Please circle the appropriate medical symptom(s).

- a) Failing or double vision
- b) Ear drainage, hearing loss, dizziness, ringing
- c) Nosebleeds drainage sinus pain nasal obstruction
- d) Frequent sore throats, lump in neck, hoarseness
- e) Frequent cough, wheezing, shortness of breath
- f) Chest pain, irregular beats
- g) Stomach pain, nausea, vomiting, diarrhea, bleeding
- h) Urinary burning, bleeding, pain, or difficulty urinating
- i) Seizures, convulsions, or memory loss
- j) Skin lesions, benign or malignant
- k) Sudden weight gain or loss, fever, chills or sweats
- l) Is there a chance you are currently pregnant? Yes/No

**Have you every had any surgery or been in the hospital: YES/NO If yes, please explain:**

<b>Year</b>	<b>Surgical Procedure/Reason for Hospitalization</b>	<b>Reason</b>

Have you had any serious injuries, such as head trauma, broken bones, concussion, or loss of consciousness? YES / NO

If Yes, please give the date and type of injury: \_\_\_\_\_

Do you or any member of your family have a history of problems with anesthesia or bleeding? YES / NO

If Yes, please explain: \_\_\_\_\_

In your family (parents, grandparents, aunts, uncles, sisters, brothers) is there a history of: (please circle the condition)

- Heart Disease                      High Cholesterol                      Stroke                      High Blood Pressure
- Diabetes                              Allergies                              Asthma                      Hearing/ear problems
- Bleeding or bruising problems                      Cancer (please specify what type if applicable) \_\_\_\_\_

No significant Past Family History

Do you smoke? YES / NO If yes, amount/day: \_\_\_\_\_ Number of years: \_\_\_\_\_

If you have smoked in the past, when did you quit? \_\_\_\_\_ How much did you smoke a day? \_\_\_\_\_

Do you consume alcohol? YES / NO If Yes, please indicate amount and frequency: \_\_\_\_\_

Is there a personal history of substance abuse? YES / NO If Yes, please explain: \_\_\_\_\_

If the patient is a minor, is he or she enrolled in a day care facility? YES / NO

If the patient is a minor, is he or she exposed to cigarette smoke? YES / NO

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Prior Testing For this Condition: YES / NO If Yes, please indicate the date of the test \_\_\_\_\_ and what tests were performed? \_\_\_\_\_.