

MEDICAL AND SURGICAL HISTORY

Please help us serve you better by completing your medical history before you see the Doctor.
Your medical record is strictly confidential.

Date _____

Name : _____ Date of Birth: _____

Height: _____ Weight: _____

Reason you are seeing the doctor today: _____

How long have you had this problem: _____

How many times have you been treated for this problem in the past year? _____

What medications or tests have you received for this problem in the past? _____

Medical Information

Allergic to any medications? No _____ Yes _____ If yes, please indicate: _____

List medications you are taking now: _____

Do you take aspirin? No _____ Yes _____ How often? _____

List any food or environmental allergies you may have: _____

List all previous medical problems: _____

List all previous surgeries: _____

Social History

Do you smoke tobacco? Past _____ Present _____ Never _____ Packs per day on average _____

How many years have you smoked? _____ Date you quit? _____

Do you use chewing tobacco or smoke cigars? No _____ Yes _____ Amount per day? _____

Do you drink alcohol? _____ amount per day? _____

Family History

Please list any illnesses which run in your family. Include any bleeding disorders or bad reactions to anesthesia during surgeries: _____

PLEASE CHECK "YES" TO CONDITIONS YOU ARE CURRENTLY EXPERIENCING

GENERAL YES

- 1. Fever
- 2. Chills
- 3. Weight loss
- 4. Night sweats
- 5. Other _____

EARS YES

- 1. Hearing loss - gradual
- 2. Hearing loss - sudden
- 3. Pain
- 4. Ringing
- 5. Dizziness or vertigo
- 6. Frequent infections
- 7. Other _____

NOSE YES

- 1. Nose bleeds
- 2. Injury
- 3. Congestion
- 4. Runny nose
- 5. Mouth breather
- 6. Other _____

THROAT YES

- 1. Frequent sore throats
- 2. Difficulty swallowing
- 3. Hoarseness
- 4. Foreign body
- 5. Thyroid problems
- 6. Swollen tonsils
- 7. Other _____

EYES YES

- 1. Cataracts
- 2. Glaucoma
- 3. Distorted vision
- 4. Other _____

HEART YES

- 1. High blood pressure
- 2. Chest pain
- 3. Irregular heart beat
- 4. Previous heart attack
- 5. Other _____

LUNGS YES

- 1. Bronchitis/chronic cough
- 2. Asthma/wheezing
- 3. Congestion
- 4. Other _____

ALLERGY/ IMMUNE YES

- 1. Seasonal allergies
- 2. Itchy eyes
- 3. Runny Nose
- 4. Allergy testing in past
- 5. HIV or AIDS

GASTROINTESTINAL YES

- 1. Indigestion or Heartburn
- 2. Ulcers
- 3. Diarrhea
- 4. Diverticulitis
- 5. Gall bladder trouble
- 6. Nausea & vomiting
- 7. Other _____

URINARY TRACT YES

- 1. Kidney problems
- 2. Painful urination
- 3. Bloody urination
- 4. Prostate problems (men)
- 5. Other _____

MUSCULOSKELETAL YES

- 1. Back pain
- 2. Weakness of limbs
- 3. Arthritis
- 4. Other _____

NEURO/PYSCH YES

- 1. Numbness
- 2. Migraine headaches
- 3. Seizures
- 4. Convulsions
- 5. Stroke
- 6. Depression
- 7. Other _____

ENDOCRINE YES

- 1. Thyroid disorders
- 2. Diabetes
- 3. Menopause (women)
- 4. Hormonal replacement
- 5. Pregnant (women)

BLOOD DISORDERS YES

- 1. Low blood counts
- 2. Free bleeding
- 3. Blood clots
- 4. Blood disorders
- 5. Hepatitis
- 6. Other _____

Patient Name _____ Date _____