

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? _____ packs per day? _____

If you smoked tobacco previously, when did you discontinue? _____

Do you use smokeless tobacco? _____ quantity 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 MARK "YES" OR "NO" TO THE FOLLOWING QUESTIONS

GENERAL YES NO

- 1. Fever YES NO
- 2. Chills YES NO
- 3. Weight loss YES NO
- 4. Night sweats YES NO
- 5. Other _____

EARS YES NO

- 1. Hearing loss - gradual YES NO
- 2. Hearing loss - sudden YES NO
- 3. Pain YES NO
- 4. Ringing YES NO
- 5. Dizziness or vertigo YES NO
- 6. Frequent infections YES NO
- 7. Other _____

NOSE YES NO

- 1. Nose bleeds YES NO
- 2. Injury YES NO
- 3. Congestion YES NO
- 4. Runny nose YES NO
- 5. Mouth breather YES NO
- 6. Other _____

THROAT YES NO

- 1. Frequent sore throats YES NO
- 2. Difficulty swallowing YES NO
- 3. Hoarseness YES NO
- 4. Foreign body YES NO
- 5. Thyroid problems YES NO
- 6. Swollen tonsils YES NO
- 7. Other _____

EYES YES NO

- 1. Cataracts YES NO
- 2. Glaucoma YES NO
- 3. Distorted vision YES NO
- 4. Other _____

HEART YES NO

- 1. High blood pressure YES NO
- 2. Chest pain YES NO
- 3. Irregular heart beat YES NO
- 4. Previous heart attack YES NO
- 5. Other _____

LUNGS YES NO

- 1. Bronchitis/chronic cough YES NO
- 2. Asthma/wheezing YES NO
- 3. Congestion YES NO
- 4. Other _____

GASTROINTESTINAL YES NO

- 1. Indigestion or Heartburn YES NO
- 2. Ulcers YES NO
- 3. Diarrhea YES NO
- 4. Diverticulitis YES NO
- 5. Gall bladder trouble YES NO
- 6. Nausea & vomiting YES NO
- 7. Other _____

URINARY TRACT YES NO

- 1. Kidney problems YES NO
- 2. Painful urination YES NO
- 3. Bloody urination YES NO
- 4. Prostate problems (men) YES NO
- 5. Other _____

MUSCULOSKELETAL YES NO

- 1. Back pain YES NO
- 2. Weakness of limbs YES NO
- 3. Arthritis YES NO
- 4. Other _____

NEURO/PYSCH YES NO

- 1. Numbness YES NO
- 2. Migraine headaches YES NO
- 3. Seizures YES NO
- 4. Convulsions YES NO
- 5. Stroke YES NO
- 6. Depression YES NO
- 7. Other _____

ENDOCRINE YES NO

- 1. Thyroid disorders YES NO
- 2. Diabetes YES NO
- 3. Menopause (women) YES NO
- 4. Hormonal replacement YES NO
- 5. Pregnant (women) YES NO

BLOOD DISORDERS YES NO

- 1. Low blood counts YES NO
- 2. Free bleeding YES NO
- 3. Blood clots YES NO
- 4. Blood disorders YES NO
- 5. Hepatitis YES NO
- 6. Other _____

ALLERGY/IMMUNE YES NO

- 1. Seasonal allergies YES NO
- 2. Itchy eyes YES NO
- 3. Runny nose YES NO
- 4. Allergy testing in past YES NO
- 5. HIV or AIDS YES NO