PAST MEDICAL HISTORY

TODAY'S DATE _____ **MEDICAL RECORD NUMBER** _____

PATIENT NAME _____ **DATE OF BIRTH** _____

MEDICAL DOCTOR _____ **PHONE NUMBER** _____

CARDIOLOGIST _____ **PHONE NUMBER** _____

EMAIL _____

PAST MEDICAL HISTORY

Have you ever been treated for any of the following? (Please check)

_____ Arthritis	_____ Bronchitis	_____ Cancer
_____ Diabetes	_____ Emphysema	_____ Epilepsy
_____ Heart Attack	_____ Heart Disease	_____ Hepatitis
_____ High Blood Pressure	_____ Immunodeficiency Disease	_____ MRSA
_____ Stroke	_____ Ulcers	

Have you ever had surgery? YES NO Please explain _____
_____
_____

Have you ever had an infection that was treated with IV antibiotics or hospitalization? YES NO
Please explain _____

CURRENT MEDICATIONS

Medication	Dose	Frequency	Condition

List any over the counter medications (diet, allergy, vitamins, herbal, etc.) _____
_____

ALLERGIES _____

SOCIAL HISTORY

Marital status (circle one) Single Married Divorced Widowed Do you live alone? YES NO
Children YES NO Number _____ Ages_____
Alcohol use YES NO Circle drinks per week: 1-6 6-12 12-18 >18
Tobacco use YES NO Packs per day_____

Continued on back →

FAMILY HISTORY

Are there any diseases that run in your family (diabetes, rheumatoid arthritis, bleeding disorders or anesthetic complications such as malignant hyperthermia)? _____
_____

Mother Alive Deceased Cause _____
Father Alive Deceased Cause _____

REVIEW OF SYMPTONS (circle all that apply to you within the last two years)

Constitutional Symptoms (fever, weight loss, double vision)
Explain _____

Eyes (double vision, blurring, glasses)
Explain _____

Ears, Nose, Throat, Mouth (deafness, sinusitis, hoarseness, vertigo)
Explain _____

Cardiovascular (chest pain, palpitations)
Explain _____

Respiratory (short of breath, asthma, cough)
Explain _____

Stomach/Intestinal (appetite loss, weight change, diarrhea, constipation, abdominal pain)
Explain _____

Urology (hesitancy, incontinence, burning with urination, menstrual problems)
Explain _____
Muscular Skeletal (fracture, sprain, joint pain/swelling, arthritis)
Explain _____

Skin/Breast (rashes, lesions, scars)
Explain _____

Neuro (speech, swallowing problems, stroke, seizures, headaches)
Explain _____

Psych (depression, hallucinations, sleep disturbances)
Explain _____

Endocrine (growth/hair changes, excess thirst, decreased energy)
Explain _____

Hematologic/Immunologic (easy bruising, blood clots, bleeding disorders)
Explain _____

DOCTOR'S SIGNATURE _____ **DATE** _____