

# MEDICAL HISTORY

**NAME** \_\_\_\_\_ **AGE** \_\_\_\_\_ **HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_ REFERRED BY DR \_\_\_\_\_

**ALLERGIES TO MEDICATIONS** \_\_\_\_\_

What are your concerns for today's visit? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_ Is this the result of an injury? \_\_\_\_\_ Date of injury? \_\_\_\_\_

**PREVIOUS HOSPITAL STAYS/SURGERIES** (Include tonsils and ear tubes) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS YOU ARE TAKING** (amounts, times per day) (include aspirin, antacids, birth control, herbals, cold, sinus, allergy) \_\_\_\_\_

\_\_\_\_\_

**DO YOU HAVE/HAD ANY OF THE FOLLOWING?** If **yes**, please circle those that apply:

Allergies	Cancer	Fainting	Hearing Loss	Kidney Disease	Stroke
Asthma	Diabetes	Hay Fever	Heart Disease	Liver Disease	Thyroid Disease
Bleeding Problems	Dizziness	Headaches	Hypertension	Rheumatoid Arthritis	Tuberculosis

**DO YOU HAVE ANY OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*WOMEN ONLY:* Are you pregnant? \_\_\_\_\_ Month of gestation? \_\_\_\_\_

**REVIEW OF SYSTEMS** Write YES if part of CURRENT problem or CHECK (✓) if you have these SYMPTOMS:

Chest Pain _____	Cough _____	Daytime Sleepiness _____	Ear Pain Itch _____	Joint Pain _____
Irregular Heart Rate _____	Hoarseness _____	Insomnia _____	Sinus Pressure/Pain _____	Muscle Pain _____
Heartburn _____	Throat Clearing _____	Fatigue _____	Sneezing _____	Skin rash/New Lesion _____
Shortness of Breath _____	Throat Dryness/Itch _____	Vision Problems _____	Post Nasal Drip _____	Swollen Glands/Lymph Nodes _____
Weight loss or gain _____	Snoring/Sleep Disturb _____	Depression _____	Watery/itchy eyes _____	Problems with Urination _____

## SOCIAL HISTORY

What is your occupation? \_\_\_\_\_

**TOBACCO HISTORY** (ie, smoke, chew, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_ If you have quit, how long ago? \_\_\_\_\_

**ALCOHOL USE?** Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_ If you have quit, how long ago? \_\_\_\_\_

**FAMILY HISTORY:** Enter relationship name (i.e.; brother, mother).

Problems with

Anesthesia: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ Cancer: \_\_\_\_\_ Hearing Loss: \_\_\_\_\_ Asthma: \_\_\_\_\_

Allergies: \_\_\_\_\_ Bleeding Problem: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Migraines: \_\_\_\_\_ Stroke: \_\_\_\_\_

**I represent the information provided in this form is true, accurate and complete.**

Signature \_\_\_\_\_ Date \_\_\_\_\_