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PATIENT MEDICAL HISTORY INFORMATION

Patient Name: _____

Brief Description of the reason for today's visit: _____

Primary Care Physician: _____ City/State: _____

Secondary Care Physician: _____ City/State: _____

General Health History

Please list all of your past and present major medical problems

.....PROBLEMS	Approximate Date

Please list the operations (surgeries) you have had

.....OPERATIONS.....	Approximate Date

ALLERGIES: Please list MEDICATIONS to which you are ALLERGIC.
 How are you allergic? (for example; rash, difficulty breathing, nausea, vomiting, diarrhea, palpitation, blood urine.)

DRUG	Type of Reaction
1.	
2.	
3.	
4.	

5.	
Are you allergic to other substances, i.e., tape, iodine, latex, food?	
1.	
2.	
3.	

MEDICATIONS: Please list your present medications including over-the-counter medications, herbal remedies, and any of the following: aspirin; Bufferin; headache pills or powders; Alka-Seltzer; blood pressure pills; cortisone-like medications; cough medications; heart medications; hormones; insulin or diabetic pills; iron or blood medications; laxatives; sleeping pills; thyroid medications; tranquilizers; weight reducing pills; blood thinner; dilantin; injections; water pills; antibiotics; barbiturates; birth control pills; dietary supplements.

MEDICATION	DOSE (milligrams)	How many times a day?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

FAMILY HISTORY: Do any major medical problems run in your family? Include consideration of the following: diabetes, kidney disease, cancer, bleeding problems, breast problems, thyroid problems, inflammatory bowel disease (colon disease, ulcerative colitis). Please list your primary relatives and the states of their health:

	Age	Health Problems	Age at death (if deceased)	Cause of death (if deceased)
Father				
Mother				
Siblings				
Brother Sister				
Brother Sister				
Brother Sister				
Children				

Personal Habits:

Drink: Hard Liquor, Beer, Wine (circle)

Currently: How much in an average month? _____

Have you ever had significant intake of alcohol? Yes No

Smoking: Do you smoke cigarettes currently? Yes No

Have you smoked in the past? Yes No

When did you start smoking? _____

When did you quit smoking (if you have)? _____

How much did you (or do you) smoke? _____

Other Substances: Have you used street drugs? Yes No

Within the past 90 days? Yes No

REVIEW OF HEALTH

Do you have, have you had, or have you been treated for any of the following: (circle)

If you do not have, have not had, have not been treated for any of the following, circle NONE in the appropriate category

GENERAL: Fevers, weight loss, night sweats, cold or heat intolerance, diabetes, low blood sugar, bleeding problems? NONE

Comments: _____

NEUROLOGICAL: Convulsions (seizures), epilepsy, dizziness, fainting spells, loss of consciousness, fever or frequent headaches, migraines; disturbances of vision, smell, taste, difficulty swallowing; difficulty speaking, difficulty moving or walking, involuntary movements or tremor, abnormal numbness or sensation, drooping of the face, nervousness; mental illness, stroke, or any other disorder of the brain or nervous system?

NONE

Comments: _____

CARDIAC (HEART): Rheumatic fever, heart murmur, damaged heart valves, heart attack, angina pectoris, chest pain, shortness of breath, early shortness of breath when exercising, awaken at night short of breath, difficulty breathing lying down, swelling of feet, heart failure, palpitations, irregular pulse, elevated blood pressure, or any other disorders of the heart or blood vessels?

NONE

Comments: _____

RESPIRATORY (CHEST AND LUNGS): Tuberculosis, persistent cough or hoarseness, pleurisy, blood spitting, asthma, respiratory infections, or other disease of lungs or respiratory system?

NONE

Comments: _____

GASTROINTESTINAL (DIGESTIVE): Difficulty or pain on swallowing, heartburn, nausea or vomiting, vomiting of blood or dark material, gallbladder disease, duodenal or gastric ulcer, indigestion, liver disease, jaundice, hepatitis, cirrhosis, pancreatitis, appendicitis, colitis, diverticulitis, hemorrhoids, rectal bleeding, pain on defecation, black tarry stools, constipation, diarrhea, change in bowel habits, abdominal pain, any other disease of the intestinal tract?

NONE

Comments: _____

URINARY (KIDNEYS, BLADDER): Kidney failure or insufficiency, nephritis, kidney stone or colic, blood or pus in urine; pain or burning with urination, frequent or recurrent bladder infections, kidney infection

(pyelonephritis), difficulty passing urine, arising from bed to urinate more than once a night, incontinence, or any other disorder of the bladder, kidney or urinary system? NONE

Comments: _____

REPRODUCTIVE ORGANS:

WOMEN: Previous pregnancies _____ Previous deliveries _____ Cesarean Sections? _____

Are you now pregnant? _____ Date of last pap? _____ Date of last mammogram? _____

Irregular or abnormally heavy periods, vaginal discharge, hysterectomy, removal of the ovaries and/or tubes, cancer of the uterus, cervix or vagina, sexually transmitted diseases, previous breast masses, nipple discharge, hernia, any disorder of the breast or pelvic organs, or any other female disorder, including abnormal pregnancy? NONE

Comments: _____

MEN: Sexually transmitted disease, infection of penis, testicles, prostate, or groin; pain or masses in the genitals, penile discharge, enlarged prostate, impotence, hernias? NONE

Comments: _____