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MEDICAL HISTORY FORM

NAME_____

DATE OF BIRTH _____ **TODAY'S DATE** _____

Describe the reason for your visit today:

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems:

Kidney Disease
Kidney Stones
Kidney Infection
Heart disease
Congestive Heart Failure
Hypertension (High blood pressure)
High cholesterol
Blood disorder
Retina disorder
Other health problems:

Liver disease
Hepatitis
COPD
Cancer
Diabetes
Blood transfusion
Thyroid problem
Stroke

LIST HOSPITALIZATIONS AND SURGERIES, including date and hospital:

_____

_____

ALLERGIES: _____

MEDICATIONS: _____

_____

_____

Tobacco Use: ____Current _____Start date ____ Cigarettes/Cigars/day ___Chew

____Never ____Former ____Quit date

Alcohol Use: ___Yes ____Drinks/day _____ No

Drug Use: ____Yes _____Type ____No

Women's Gynecologic History:

Pregnancies: _____ # Deliveries: _____ # Abortions _____ # Miscarriages _____
Hypertension during pregnancy? _____ Diabetes during pregnancy? ___ 1st day most recent period: _____

REVIEW OF SYSTEMS: Please check any current problems you have:

Constitutional
__Fevers/chills/sweats
__Unexplained weight loss/gain
__Fatigue/weakness
__Excessive thirst or urination
Cardiovascular
__Chest pain/discomfort
__Leg pain with exercise
__Palpitations
Gastrointestinal
__Abdominal pain
__Blood in bowel movement
__Nausea/vomiting/diarrhea
Musculoskeletal
__Muscle/joint pain
Skin
__Rash or mole change
Neurological
__Headaches
__Dizziness/light-headedness
__Numbness
__Memory loss
__Loss of coordination
Other (please specify) _____ _____

Eyes
__Change in vision
Ears/Nose/Throat/Mouth
__Difficult hearing/ringing in ears
__Problems with Teeth or Gums
Respiratory
__Cough/wheeze
__Difficulty breathing
Genitourinary
__Prostate Problems
__Nighttime Urination
__Leaking urine
__Unusual Vaginal Bleeding
__Discharge: penis or vagina
__Sexual function problems
__Blood in Urine
Psychiatric
__Anxiety/stress
__Problems with Sleep
__Depression
Blood/Lymphatic
__Unexpected Lumps
__Easy bruising/bleeding

FAMILY HISTORY: Please check if family members have had any of the following conditions:

	Mother	Father	Brother	Sister	Son	Daughter	Other
Genetic disease/Birth defects							
Anemia							
Anesthesia problem							
Arthritis							
Hearing Problems							
Heart Attack							
Stroke							
High Blood Pressure							
Bleeding problems							
High Cholesterol							
Cancer							
Kidney Disease							
Lupus							
Diabetes							
Age and cause of Death							