# MEDICAL HISTORY

Please answer all of the following questions prior to your first examination. It will help your physician to know not only about your health but also about your family.

TODAY'S DATE _____

NAME_____ ADDRESS _____

PHONE_____ SEX_____ DATE OF BIRTH_____ AGE _____ MARITAL STATUS_____

EDUCATION _____ OCCUPATION _____ HOW LONG _____ EMPLOYER_____

DO YOU SMOKE? _____ HOW LONG? _____ HOW MANY PACKS/WK? _____ USE ALCOHOL? _____ HOW MUCH? _____

## FAMILY HISTORY:

| | Alive | (Present health condition) | Deceased | (Cause of death) |
|---|---|---|---|---|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ | _____ |
| | # Alive | (Any health problems) | # Deceased | (Cause of death) |
| Brothers | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ |
| | # Alive | (Ages & any health problems) | # Deceased | (Cause of death) |
| Children | _____ | _____ | _____ | _____ |

Check illnesses which have occurred in your blood relatives: _____Diabetes _____ Cancer _____Bleeding Problems _____ Migraine

_____Suicide _____ High Blood Pressure _____Heart Problems

## PERSONAL HISTORY:

Family Doctor_____ Referring Doctor _____

Date of last physical _____any abnormal findings_____

CHECK if immunized for ___Small Pox _____ Tetanus _____Polio _____ Typhoid ____ Other _____

Operations (Type, Date, Hospital, Surgeon)

_____

_____

_____

_____

OTHER HOSPITAL ADMISSIONS BESIDES SURGERY (List problem, dates, hospital, admitting doctor)

_____

_____

LIST ALL ALLERGIES (to medications, foods, etc.) _____

What medication are you now taking? _____

MENSTRUATION: Date of last period _____ Onset at age _____ Regular? _____ # of Miscarriages_____

Last mammogram date: _____

Are you on Birth Control Pills? _____

WEIGHT: _____ HEIGHT: _____

**What Is Your Main Reason For Your Visit Today?**_____

(PLEASE SEE OTHER SIDE)

## Circle all the things that are bothering you now or within the past year:

**General:** fever, chills, soaking sweats, lumps

**Eyes:** eye pain, vision loss, spots or floaters, infections, injury, glaucoma, cataracts
Date of last eye exam: _____

**ENT:** dizziness, hearing loss, ringing, ear pain, infections, sinus headaches, nasal drainage, nosebleeds, mouth bleeds, sores, voice change, difficulty swallowing

**Heart:** chest pain, palpitations, irregular pulse, high blood pressure

**Lungs:** cough, dark sputum, bloody sputum, shortness of breath, wheezing, need high pillows, awaken at night choking, asthma, bronchitis or pneumonia

**Digestive:** chronic indigestion, frequent nausea/vomiting, changes in bowel habits, diarrhea, constipation. Last hemoccult exam (if over 50): _____

**Urinary:** burning urine, bloody urine, infection, VD, difficulty in starting stream, dribbling, get up to urinate _____time(s) a night.

**Muscular/Skeletal:** Stiff / swollen / painful joints, weakness, bad back, varicose veins, muscle pain, history of fractures, muscle cramping, limitations on walking

**Neuro:** nervousness, paralysis, numbness, fainting, stroke, tensions, tingling, weakness, tremors or paralysis

**Blood:** anemia, bleeding tendencies, easy bruising, fatigue

**Glands:** thyroid disorder, diabetes, unexplained changes in height or weight, previous or current hormone therapy, hair change, skin change, heat/cold intolerance, loss of sex drive

**Psych:** depression, anxiety, stress-related problems

**Allergic/Immune:** eczema, hives and/or itching, frequent sneezing, chronic clear nasal discharge, conjunctivitis, any allergy that causes interference with activities of daily living

**Skin & Breast:** sores, color changes of lesions, breast pain / tenderness / swelling, history of nipple discharge / changes. Date of last mammogram: ____ / ____ / ____

Comments: _____ Dr. _____
(date)

Comments: _____ Dr. _____
(date)

Comments: _____ Dr. _____
(date)

Comments: _____ Dr. _____
(date)