



12000 RICHMOND AVE SUITE 180
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MEDICAL HISTORY FORM

DATE: ___/___/___

DATE OF BIRTH: ___/___/___

Name: (First, Last, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Age: _____
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PERSONAL HEALTH HISTORY

ALLERGIES TO MEDICATIONS OR OTHER AGENTS <input type="checkbox"/> NONE	
Name of Medication or "Other" Agent	Type of Reaction

CURRENT MEDICATIONS (Name, Strength, Frequency): <input type="checkbox"/> NONE		
1.	2.	3.
4.	5.	6.

HOSPITALIZATIONS/SURGERIES <input type="checkbox"/> NONE		
Year	Reason	Hospital

Have you ever had any of the following? (Please check all that apply) <input type="checkbox"/> NONE		
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cancer
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Psychiatric Disorder (e.g. Anxiety, Depression)
<input type="checkbox"/> Lung Disease (Asthma, TB, Pneumonia, Emphysema)		
List any other medical problems:		

REVIEW OF SYSTEMS

Do you currently have any of the following:

General	Ear/Nose/Throat	Gastrointestinal	Musculoskeletal	Psychiatric
<input type="checkbox"/> Chills	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Fever	<input type="checkbox"/> Difficulty hearing	<input type="checkbox"/> Constipation	<input type="checkbox"/> Joint Redness	<input type="checkbox"/> Depression
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Difficulty speaking	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> History of Alcohol Dependence
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> History of Drug Dependence
<input type="checkbox"/> Recent weight loss	<input type="checkbox"/> Ringing in your ears	<input type="checkbox"/> Nausea	<input type="checkbox"/> Muscle Pain	Endocrine
<input type="checkbox"/> Recent weight gain	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Dark black stools; blood in stools	<input type="checkbox"/> Muscle Cramping	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Sore throats	<input type="checkbox"/> Ulcers	Neurological ↑	<input type="checkbox"/> Hypoglycemia (Low Blood Sugar)
Eyes	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Recent change in bowel habits	<input type="checkbox"/> Numbness	Hematological/Immunologic
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Earaches	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Tingling	<input type="checkbox"/> Swollen lymph nodes
<input type="checkbox"/> Tearing	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Redness	Cardiovascular	Genitourinary	<input type="checkbox"/> Headache	<input type="checkbox"/> Anemia
<input type="checkbox"/> Itching	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Burning on urination	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Vertigo (Dizziness)	Respiratory
Skin/Breast ↑	<input type="checkbox"/> Swelling of feet/ankles	<input type="checkbox"/> Frequent urinary tract infections	<input type="checkbox"/> Tremors	<input type="checkbox"/> Chronic cough/sputum production
<input type="checkbox"/> Rash	<input type="checkbox"/> Murmur	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Hands falling asleep	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Urethral discharge		<input type="checkbox"/> Shortness of breath with exertion
<input type="checkbox"/> Bruises		<input type="checkbox"/> Changes in urinary stream		<input type="checkbox"/> Shortness of breath with rest

SOCIAL HISTORY

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, how many drinks per week?		
Tobacco	Do you currently use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	How many years?	How many packs per day?	
	Chew # per day	Pipe per day	Cigars per day
	If you previously smoked, when did you quit?		
	How many packs did you smoke per day?		
	How many years did you smoke?		
Drugs	Do you currently use recreational or street drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	

OCCUPATIONAL HISTORY

Current Occupation:
How many years:
If unemployed, when did you last work:

Signature

Date