

PATIENTS MEDICAL HISTORY

DATE: _____

1. FULL NAME: _____
2. Describe briefly your reason for coming to my office: (date of injury, if applicable): _____

GENERAL HEALTH

1. Are you allergic to any foods? Yes No
 If so, list foods & type of reaction: _____
2. Are you allergic to any medication: Yes No
 If so, list medication & type of reaction: _____
3. Do you have any other allergies such as creams, tape, latex, etc? Yes No
 If so, please list: _____

CURRENT MEDICATIONS

(Include herbs, vitamins, aspirin, Advil, anti-inflammatory's & any other over-the-counter medications. Provide a separate sheet if necessary)

MEDICATION	STRENGTH	DOSAGE	FREQUENCY	REASON

PAST MEDICAL HISTORY

Do you bruise or BLEED EASILY? Yes No

4. Are you being treated for any health problems now or have you been treated with in the past five years? Yes No
 if so, What type of illness _____

5. Have you ever been treated for one of the following:

	Yes No			Yes No	
	Yes	No		Yes	No
Diabetes HgC A1C date:			HIV/AIDS		
Tuberculosis			Liver Disease or Hepatitis		
Kidney Disease			Blood or Bleeding problem		
High Blood Pressure			Cancer		
Heart or Circulatory Disease			Arthritis		
Heart Attack			Epilepsy or seizures		
Lung problems or pneumonia			Sleep Apnea requiring a mask		
Thyroid Problem			Psychological or Emotional problems		

6. Do you ever experience one of the following:

	Yes	No		Yes	No
Cough up blood			Have Stomach problems		
Vomit up blood/blood in stools			Feel faint or dizzy		
Have shortness of breath			Have nose problems (runny or stuffy)		
Have chest pain			Have dry eyes		
Have heart palpitations			Have problems w/healing		
Have skin Disorders			Any staph (MRSA) infections		

Please explain all yes answers: _____

7. Please list any operations you have had, including dates: _____

8. Have you had any major injuries? Yes No If yes, when and what happened:

9. Where & When was your last mammogram? _____

10. Where & When was your last EKG? _____

11. Present weight: _____ Weight one year ago: _____ Best weight for you: _____ Height: _____

SOCIAL HISTORY

1. Marital Status: _____

2. How many children do you have: _____

3. Tobacco use? Yes No Smoke Chew How much per day? _____

When did you start? _____ How long did you smoke? _____ When did you quit? _____

4. What type of work do you do _____

5. Do you drink alcohol? _____ How much & how often? _____ When was you last drink? _____

6. Any history of illicit or IV drug use? Yes No

FAMILY HISTORY

Yes No Who

Yes No Who

Coronary artery disease				Melanoma			
Heart Attack				Breast Cancer			
Malignant Hyperthermia				Skin Diseases			
Skin Cancer							