MEDICAL HISTORY FORM

Patient Name: ____ **Date:** ___________________

Height: ______________ **Weight:** __________ **Age:** _________**Birthdate:** _____/_____/_____

Do you currently have or have had in the past, any of the following medical problems? If yes, please put a check in the box and list the name of the treating physician below.

High Blood Pressure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer (Type _________)	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Ulcers/Gastritis/GERD	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	(please circle which one)		
Emphysema/COPD	☐ Yes	☐ No	High Cholesteral	☐ Yes	☐ No
Other conditions (please list below)	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No

____

PREVIOUS SURGERIES: (Please list surgery and date it occurred)

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________
7. ____________________________________
8. ____________________________________
9. ____________________________________
10. ____________________________________

CURRENT MEDICATIONS: (Please List Medication, Dosage and How often the Medication is taken)

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. _______ ______________________________
7. ____________________________________
8. ____________________________________
9. ____________________________________
10. ____________________________________

Do you have any allergies:

Drug/Food: ☐ Yes ☐ No If yes, please list:____

If allergic to an antibiotic, what reaction occurred & when: ______________________________________

FAMILY INFORMATION:

Do you have any family members that either now or in the past have a history of:

Heart trouble: ☐ Yes ☐ No Relationship: _______________________

If yes, please explain: ____

Cancer: ☐ Yes ☐ No Relationship: _______________________

If yes, please explain: ____

Diabetes: ☐ Yes ☐ No Relationship: _______________________

If yes, please explain: ____

SPECIFIC HEALTH HISTORY

CARDIOLOGY

Have you *ever* seen a cardiologist (heart specialist)? ☐ Yes ☐ No If yes, name of

Dr:____ If yes, when? _______________

Why? ____

Have you ever had a:

Heart attack	☐ Yes	☐ No	If yes, when? ____________
Clot	☐ Yes	☐ No	If yes, when? ____________
Stroke	☐ Yes	☐ No	If yes, when? ____________
TIA	☐ Yes	☐ No	If yes, when? ____________
Aneurysm	☐ Yes	☐ No	If yes, when? ____________
Abnormal Pulse	☐ Yes	☐ No	If yes, when? ____________
Clot in Lung	☐ Yes	☐ No	If yes, when? ____________
Brain Injury	☐ Yes	☐ No	If yes, when? ____________
Murmur	☐ Yes	☐ No	If yes, when? ____________
Enlarged Heart	☐ Yes	☐ No	If yes, when? ____________

Have you ever taken:

Nitroglycerin	☐ Yes	☐ No	If yes, when? ____________
Coumadin	☐ Yes	☐ No	If yes, when? ____________
Warfarin	☐ Yes	☐ No	If yes, when? ____________
Aspirin	☐ Yes	☐ No	If yes, When? ____________

PULMONOLOGY

Have you *ever* seen a pulmonologist (lung specialist)? ☐ Yes ☐ No

If yes, name of Dr: __________________________ If yes, when? _______________

Why? ____

Have you ever had:

Asthma	☐ Yes	☐ No	If yes, when? ____________
Lung Problems	☐ Yes	☐ No	If yes, when? ____________
Breathing Trouble	☐ Yes	☐ No	If yes, when? ____________

PREGNANCY

If you have been pregnant did you have:

Clots	☐ Yes	☐ No
Gestational Diabetes	☐ Yes	☐ No

Patient name: ____ **Date:** _______________

Do you drink? ☐ Yes ☐ No If yes, how much? ____________________
Do you smoke? ☐ Yes ☐ No If yes, how much? ___________________
Do you use drugs? ☐ Yes ☐ No If yes, what kind & how much?

REVIEW OF SYSTEMS

Constitution Systems:
Recent Weight Change ☐ Yes ☐ No
If yes: ☐ weight gain ☐ weight loss
Fever ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No
Other: ___________________________________

Eyes:
Wear glasses/contacts ☐ Yes ☐ No
Blurred or double vision ☐ Yes ☐ No
Glaucoma or cataracts ☐ Yes ☐ No
Other: ___________________________________

Ears/Nose/Mouth/Throat:
Hearing loss/ringing ☐ Yes ☐ No
Chronic sinus problem/rhinitis ☐ Yes ☐ No
Dentures Upper/Lower ☐ Yes ☐ No
Other: ___________________________________

Psychiatric:
Memory loss or confusion ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Other: ___________________________________

Respiratory:
Chronic or frequent cough ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Other: ___________________________________

Gastrointestinal:
Nausea or vomiting ☐ Yes ☐ No
Frequent diarrhea ☐ Yes ☐ No
Rectal bleeding/blood in stool ☐ Yes ☐ No
Abdominal pain or heartburn ☐ Yes ☐ No
History of hepatitis ☐ Yes ☐ No
If yes, what type: ___________
Other: ___________________________________

Genitourinary:
Painful urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Incontinence or dribbling ☐ Yes ☐ No
Are You Pregnant ☐ Yes ☐ No
Other: ___________________________________

Integumentary: (skin/breast)
Rash or itching ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
Other: ___________________________________

Neurological:
Frequent/recurring headaches ☐ Yes ☐ No
Convulsions or seizures ☐ Yes ☐ No
Other: ___________________________________

Endocrine:
Heat or cold intolerance ☐ Yes ☐ No
Other: ___________________________________

Hematologic/Lymphatic:
Bleeding or bruising tendency ☐ Yes ☐ No
Past transfusion ☐ Yes ☐ No
Other: ___________________________________

Patient Signature: ________________________________ Date: __________________
Reviewed by: ________________________________ Date: __________________
Reviewed by: ________________________________ Date: __________________
(Rev 3-10-08)