

Patient Medical History

PLEASE ANSWER ALL QUESTIONS - PRINT ALL INFORMATION

NAME LAST, FIRST, MIDDLE		AGE & BIRTHDATE		MARITAL STATUS		TODAY'S DATE		YEAR OF LAST TETANUS	
OCCUPATION	EMPLOYED BY	DOMINANT HAND Right Left		HEIGHT	WEIGHT	CIRCLE IF YOU HAVE HAD RECENTLY X-RAY CAT SCAN MRI BLOOD OR URINE TEST			
REASON YOU ARE BEING SEEN TODAY									
HAVE YOU BEEN SEEN HERE WITHIN THE LAST 3 YEARS AND WHY?									

PAST HISTORY: CIRCLE & GIVE AGE OF ONSET OF ANY OF THE FOLLOWING ILLNESS YOU HAVE HAD:

Seizures	Fibromyalgia	High Cholesterol	Psoriasis	Nervous Condition
Measles	Polio	Diabetes	Mononucleosis	Eye Trouble
German Measles	Bronchitis	Eczema	Liver Disease	Valley Fever
Pneumonia	Hives	Hemorrhoids	Ear Trouble	High Blood Pressure
Emphysema	Ulcers / GERD	Hernia	Kidney Disease	Rheumatic Fever
Asthma	Hay Fever	Thyroid Disease	Kidney Stones	Heart Trouble
Arthritis	Jaundice	Sexually Transmitted Disease	Tuberculosis	

FEMALES:

Last Menstrual Period: _____ Cycle Length: _____ Age Menses Started: _____ Age Menses Stopped: _____ If Pregnant, Due Date: _____

INJURIES: List ALL Series Injuries. Include broken bones, head or back injuries, and dislocations. Give year occurred.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

SURGERY: List ANY operations not included above.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

SOCIAL HISTORY

Do you use TOBACCO now? _____ In the past? _____ Type _____ Daily Amount _____ How Long? _____

Do you use alcoholic beverages? _____ In the past? _____ Type _____ Weekly Amount _____ How Long? _____

MEDICATIONS: LIST ALL MEDICATIONS THAT YOU ARE TAKING ON A REGULAR BASIS OR FREQUENTLY. INCLUDE PRESCRIBED DRUGS, VITAMINS, ANTACIDS, BIRTH CONTROL PILLS, ETC., AND HOW OFTEN YOU TAKEN THEM.

1. _____ 6. _____ 11. _____
2. _____ 7. _____ 12. _____
3. _____ 8. _____ 13. _____
4. _____ 9. _____ 14. _____
5. _____ 10. _____ 15. _____

ALLERGIES: List ALL known MEDICATION ALLERGIES, type of reaction, and stomach trouble.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

NURSES NOTES

FAMILY HISTORY: Check if any BLOOD RELATIVE ever had:

ILLNESS	✓	RELATION	ILLNESS	✓	RELATION	ILLNESS	✓	RELATION
DIABETES			THYROID TROUBLE			ALLERGIES		
HIGH BLOOD PRESSURE			TUBERCULOSIS			ASTHMA		
HEART TROUBLE			EPILEPSY			ANEMIA		
STROKE			ARTHRITIS			GLAUCOMA		
CANCER / WHAT ORGAN?			BLOOD DISEASE			STOMACH ULCERS		
KIDNEY TROUBLE			MENTAL ILLNESS			DUODENAL ULCERS		

REVIEW OF SYSTEMS: Have YOU had any of these symptoms RECENTLY? If NOT, mark NONE.

1. CON Weight Loss Frequent Fever Loss of appetite NONE
2. EYE Blurred Vision Double Vision Vision Loss NONE
3. ENT Hearing Loss Hoarseness Trouble Swallowing NONE
4. CV Chest Pain Palpitations NONE
5. RS Chronic Cough Shortness of Breath Wheezing NONE
6. Allergy Wheezing Difficulty Breathing NONE
7. GI Heartburn, ulcers Nausea, vomiting Blood in Stool
 Hepatitis Liver Disease Diarrhea NONE
8. GU Painful Urination Blood in Urine Kidney Problems NONE
9. SK Frequent Rashes Skin Ulcers Lumps Psoriasis NONE
10. NEU Headaches Dizziness Seizures NONE
11. PSY Depression Drug/Alcohol Addiction Sleep Disorder NONE
12. ENDO Thyroid Disease Heat or Cold Intolerance Hair Loss NONE
13. HEM Easy Bleeding Easy Bruising Anemia NONE
14. M/S Gout Osteoarthritis Osteoporosis Rheumatoid Arthritis NONE