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# MEDICAL HISTORY

(Please Complete all four pages)

Date: _____

Name: _____

Age: _____ Height: _____ Weight: _____

Referring physician: _____

Address: _____

Family physician: _____

Address: _____

May we correspond with these physicians regarding your care? _____

Who referred you to this office? _____

May we thank this person for your referral? _____

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What is the purpose of this consultation? _____

How long has this problem been present? _____

# PAST MEDICAL HISTORY

ILLNESSES: (List any illnesses that requires medical attention)

HOSPITALIZATIONS: (Include date, place, reason, doctor)

OPERATIONS: (Include date)

INJURIES:

ALLERGIES: (history of skin reaction or adverse reaction to)

| | | |
|---|---|---|
| Penicillin or other antibiotic | ❑ Yes | ❑ No |
| Morphine, Demerol or other narcotic | ❑ Yes | ❑ No |
| Lidocaine or other anesthetic | ❑ Yes | ❑ No |
| Aspirin or other pain remedies | ❑ Yes | ❑ No |
| Tetanus antitoxin or other serums | ❑ Yes | ❑ No |
| Iodine, methiolate or other antiseptics | ❑ Yes | ❑ No |

OTHER DRUGS/MEDICATIONS/ALLERGIES:

Known food allergies

MEDICATIONS: (List the medications you are now taking)

| MEDICATION | DOSAGE | FREQUENCY | PURPOSE |
|---|---|---|---|

# SOCIAL HISTORY

Birthplace: _____

Where was childhood spent? _____

Marital status: single married divorced widow(er) _____

Occupation: _____

Education: (number of years) _____ Location: _____

HABITS:

Tobacco usage: ☐ No ☐ Yes Age started smoking? _____

Tobacco amount (1 pack a day?) _____

Alcohol (type and amount used) _____

Have you ever used drugs for recreational purposes? ☐ No ☐ Yes

Explain: _____

# FAMILY HISTORY

List any medical problems that run in your family (bleeding tendencies, anesthetic problems, etc.)

| RELATIVES | AGE | STATE OF HEALTH |
|---|---|---|
| Father | | |
| Mother | | |
| Spouse | | |
| Brothers | | |
| | | |
| | | |
| Sisters | | |
| | | |
| Sons | | |
| | | |
| | | |
| Daughters | | |
| | | |
| | | |

# REVIEW OF SYSTEMS:

(Check the appropriate answers and fill in the blanks where necessary)

## GENERAL:

State of health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Recent change in weight: ❑ Gain ❑ Loss How much? _____

## EYES, EARS, NOSE AND THROAT

Problem with: ❑ Eye ❑ Ear ❑ Nose ❑ Throat ❑ Sinuses ❑ No Problems

Explain: _____

_____

## RESPIRATORY:

Shortness of breath, mucous production, cough up blood, wheezing, asthma. No problems

Explain: _____

_____

## HEART:

Chest pains, high blood pressure, ankle swelling, awake at night, short of breath, shortness of breath when lying down. No problems

Explain: _____

_____

## GASTROINTESTINAL:

Abdominal pain, change in bowel habits recently, black stool, blood in stool, hemorrhoids, nausea, vomiting, history of jaundice or hepatitis. No problems

Explain: _____

_____

## GENITOURINARY:

Kidney or bladder problems, trouble urinating (burning, dribbling) No problems

Age at onset of periods Periods irregular?

Any female disorders? ❑ Yes ❑ No

Explain: _____

## MUSCULOSKELETAL:

Bone or joint trouble? No problems

Dominant hand: ❑ Right ❑ Left

## NERVOUS SYSTEM:

Seizures, fainting, headaches, dizziness, double vision, significant depression. No problems

Explain: _____

## ENDOCRINE SYSTEMS:

Diabetes, thyroid disease. No problems

Explain: _____

## HEMATOPOETIC SYSTEM:

Anemia, bruise easily, bleeding tendencies. No problems

Explain: _____

Reviewed on: _____

By: _____