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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? _____

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 ? ☐ Yes ☐ No Date stopped:

Any female disorders? ❑ Yes ❑ No Periods Irregular ? ☐ 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: _____