



# Medical History

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Name \_\_\_\_\_ Today's Date \_\_\_\_\_

What is the problem you seeing the doctor about today? \_\_\_\_\_

If this problem is the result of an accident or injury, give date (month/day/year): \_\_\_\_\_  
(best estimate if not sure)

## Personal Medical History

(Please check any of the following that have affected YOU.)

- |   |   |
|---|---|
| <input type="checkbox"/> Arthritis                          | <input type="checkbox"/> Kidney stones                              |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Liver disease                              |
| <input type="checkbox"/> Blood clots                        | <input type="checkbox"/> Malignant hyperthermia/anesthesia problems |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Mental illness                             |
| <input type="checkbox"/> COPD or Emphysema                  | <input type="checkbox"/> Pregnant now                               |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Seizures                                   |
| <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Sickle-cell anemia                         |
| <input type="checkbox"/> Gout                               | <input type="checkbox"/> Stroke                                     |
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Thyroid disorder                           |
| <input type="checkbox"/> Hepatitis                          | <input type="checkbox"/> Transient Ischemic Attack (TIA)            |
| <input type="checkbox"/> HIV/AIDS                           | <input type="checkbox"/> Ulcers                                     |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Other                                      |
| <input type="checkbox"/> Kidney failure                     | <input type="checkbox"/> None of these                              |

Please explain all items checked above: \_\_\_\_\_

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Name \_\_\_\_\_ Today's Date \_\_\_\_\_

### Surgical History

Have you had surgery?  Yes  No If yes, list all surgeries with dates and side

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_ Left / Right

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_ Left / Right

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_ Left / Right

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_ Left / Right

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_ Left / Right

### Family Medical History

(Please check any of the following that have affected a blood relative.)

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Hypertension (High Blood Pressure)         |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Kidney problems                            |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Liver disease                              |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Malignant hyperthermia/anesthesia problems |
| <input type="checkbox"/> Blood clots       | <input type="checkbox"/> Mental illness                             |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Seizures                                   |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Sickle-cell anemia                         |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Stroke                                     |
| <input type="checkbox"/> Gout              | <input type="checkbox"/> Thyroid disorder                           |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Other                                      |
| <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> None of these                              |
| <input type="checkbox"/> HIV/AIDS          |   |

Please explain all items checked above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### Social History

Occupation: \_\_\_\_\_

Sports or hobbies: \_\_\_\_\_

Who lives at home with you: \_\_\_\_\_

Have you used tobacco?  Never Started (age): \_\_\_\_\_ Type : \_\_\_\_\_  
(cigarettes, snuff, etc.)

Amount: \_\_\_\_\_ Stopped (age): \_\_\_\_\_

Do you drink alcohol?  No  Yes: Amount: \_\_\_\_\_

Do you use illegal drugs?  No  Yes: Type: \_\_\_\_\_

### Review of Systems

Please check any symptoms you currently have, and explain in space below.

**General:**  Fever  Weight loss  Fatigue  Loss of appetite

**Head:**  Headache  Head injury

**Neck:**  Pain  Stiffness

**Eyes:**  Wear glasses  Wear contact lenses  Vision changes

**Ears/Nose/Throat:**  Hearing loss  Vertigo  Nose bleed  Bleeding gums

**Cardiovascular:**  Chest pain  Irregular heart beat  Palpitations  Swollen feet

**Respiratory:**  Shortness of breath  Wheezing  Cough  Sleep apnea

**GI:**  Nausea/vomiting  Diarrhea  Constipation

Coughing up blood  Rectal bleeding  GERD/reflux

**Urinary:**  Frequent urination  Painful urination  Incontinence

**Musculoskeletal:**  Fractures  Joint pain  Swelling  Stiffness  Osteoporosis

**Skin:**  Rashes  Skin breakdown  Skin ulcers

**Neurologic:**  Loss of sensation  Paralysis  Visual changes

Loss of balance  Dizziness  Tremor

**Psychiatric:**  Depression  Anxiety  Hallucinations  Dementia

Please explain all items checked above: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

M.D. Review: : \_\_\_\_\_ Date: \_\_\_\_\_