Medical History

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X _____ X _____

Patient Signature (Guardian/POA) Physician's Review Signature

Name _____ Age _____ □Single □Married □Divorced □Widowed

Date _____ Occupation _____ All Previous Occupations _____

Birth Place _____ Birth Date _____ List all States in which you have lived _____

Education: _____ years High School _____ years College _____years Post Grad

Date of last physical examination _____ Routine Check-up – No Symptoms □

Please list all concerns for today's evaluation:

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

FAMILY HISTORY

		If Living Age	If Living Health	If Deceased Age at Death	If Deceased Cause
Father					
Mother					
Brother or Sister	1.				
	2.				
	3.				
	4.				
Spouse					
Son or Daughter	1.				
	2.				
	3.				
	4.				

Has any blood relative ever had:			Who
Cancer	□No	□Yes	
Tuberculosis	□No	□Yes	
Diabetes	□No	□Yes	
Heart Trouble	□No	□Yes	
High Blood Pressure	□No	□Yes	
Stroke	□No	□Yes	
Epilepsy	□No	□Yes	
Mental Illness	□No	□Yes	
Suicide	□No	□Yes	

PERSONAL HISTORY:

ILLNESSES: Have you ever had:

Measles	□No	□Yes
German Measles	□No	□Yes
Mumps	□No	□Yes
Chicken Pox	□No	□Yes
Whooping Cough	□No	□Yes
Scarlet Fever or Scarlatina	□No	□Yes
Diphtheria	□No	□Yes
Smallpox	□No	□Yes
Pneumonia	□No	□Yes
Pleurisy	□No	□Yes
Rheumatic Fever or Heart Disease	□No	□Yes
Arthritis or Rheumatism	□No	□Yes
Any bone or joint disease	□No	□Yes
Neuritis or Neuralgia	□No	□Yes
Bursitis, Sciatica or Lumbago	□No	□Yes
Polio or Meningitis	□No	□Yes
Nephritis	□No	□Yes
Gonorrhea or Syphilis	□No	□Yes
Gallbladder Disease	□No	□Yes
Anemia	□No	□Yes
Jaundice	□No	□Yes
Bladder Disease	□No	□Yes
Epilepsy	□No	□Yes
Migraine Headaches	□No	□Yes
Tuberculosis	□No	□Yes
Diabetes	□No	□Yes
Cancer	□No	□Yes
High or low blood pressure	□No	□Yes
Colitis or other bowel disease	□No	□Yes
Hemorrhoids or any rectal disease	□No	□Yes
Nervous Breakdown	□No	□Yes
Food, chemical or drug poisoning	□No	□Yes
Hay fever or Asthma	□No	□Yes
Hives or Eczema	□No	□Yes
Frequent infections or boils	□No	□Yes
AIDS	□No	□Yes
Any other disease	□No	□Yes

ALLERGIES: Are you allergic to

Penicillin or Sulfa	□No	□Yes
Aspirin, Codeine or Morphine	□No	□Yes
Mycins or other Antibiotics	□No	□Yes
Merthiolate or Mercurochrome	□No	□Yes
Any other drug	□No	□Yes
Any foods	□No	□Yes
Adhesive Tape	□No	□Yes
Nail polish or other cosmetics	□No	□Yes
Tetanus Antitoxin or Serums	□No	□Yes

INJURIES: Have you had any

Broken or cracked bones	□No	□Yes
Sprains	□No	□Yes
Dislocations	□No	□Yes
Concussion or head injury	□No	□Yes
Ever been knocked unconscious	□No	□Yes

TRANSFUSIONS: Have you ever had

Blood or Plasma Transfusion □No □Yes

WEIGHT:

Now _____
One Year Ago _____
Maximum _____
When _____

SURGERY: Have you had

Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

IMMUNIZATIONS: Have you had

Tetanus shot (not antitoxin which lasts only two weeks)
□No □Yes
Flu shots/Pneumovax within the last two years
□No □Yes

EKG:

Have you ever had an electrocardiogram
□No □Yes

SEX LIFE:

Do you have any concerns
□No □Yes

WOMEN ONLY – MENSTRUAL HISTORY

Age at onset _____
Regular □Yes □No □Varies
Cycle _____ days from start to finish
Flow: □Heavy □Medium □Light
Number of pads used per period _____
Any clots passed □No □Yes
Pains or cramps □No □Yes
Date of last period _____
Date of last pelvic exam _____
Date of last Pap Test _____
Results □Neg. □Pos.
Any discharge from vagina □No □Yes
If so, color _____
Amount _____
Any itching of vaginal area □No □Yes
Do you take birth control pills □No □Yes
How long have you taken them _____
Pregnancies:
How many children born alive _____
How many still births _____
How many premature births _____
How many Cesarean Sections _____
How many miscarriages _____
Any complications with pregnancy □No □Yes
Describe _____
Other _____

Do you smoke □No □Yes If yes, what quantity _____
Have you ever been advised to have any surgical operation which has not been done □No □Yes

DRUGS: *Are you taking*

Laxatives;	□never	□occasionally	□frequently	□daily
Vitamins;	□never	□occasionally	□frequently	□daily
Sleeping pills, etc.;	□never	□occasionally	□frequently	□daily
Cortisone, ACTH;	□never	□occasionally	□frequently	□daily
Thyroid	□never	□occasionally	□frequently	□daily
Appetite depressants	□never	□occasionally	□frequently	□daily
Have you ever been treated for drug habits			□No	□Yes
Have you ever taken insulin or tablets for diabetes			□No	□Yes
Have you ever taken hormone tablets or injections			□No	□Yes
Have you ever taken Fen-Phen/Redux			□No	□Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches	□No	□Yes
Fainting Spells	□No	□Yes
Dizziness on change of position	□No	□Yes
Unconscious Spells	□No	□Yes
Blurred Vision	□No	□Yes
Double Vision	□No	□Yes
Spots before eyes	□No	□Yes
Infected eyes	□No	□Yes
Pain behind eyes	□No	□Yes
Any change in vision	□No	□Yes
Do you wear glasses	□No	□Yes
When were they last checked _____		
Earaches	□No	□Yes
Discharge from Ears	□No	□Yes
Ringing in ears	□No	□Yes
Decrease in hearing	□No	□Yes
Recurrent nose bleeds	□No	□Yes
Recurrent head colds	□No	□Yes
Sinus trouble	□No	□Yes
Hay fever	□No	□Yes
Strange persistent odors	□No	□Yes
Strange taste or loss in taste	□No	□Yes
Persistent hoarseness	□No	□Yes
Difficulty swallowing	□No	□Yes
Enlarged glands	□No	□Yes
Recurrent sore throats	□No	□Yes
Recurrent sores in mouth	□No	□Yes
Soreness or bleeding of gums on brushing	□No	□Yes
Chest pain	□No	□Yes
Angina pectoris	□No	□Yes
Coughed-up blood	□No	□Yes
Pain in arm(s)	□No	□Yes
Night Sweats	□No	□Yes
Persistent cough or throat clearing not associated with a known illness (lasting more than three weeks)	□No	□Yes
Chronic or frequent cough on lying down	□No	□Yes
Wake up at night short of breath	□No	□Yes
How many pillows do you use _____		
Shortness of breath on:		
Walking several blocks	□No	□Yes
One flight of stairs	□No	□Yes
On lying down	□No	□Yes
Purple lips or fingers	□No	□Yes
Palpitations or fluttering of heart	□No	□Yes
High blood pressure	□No	□Yes
Swelling of hands, feet or ankles	□No	□Yes
At what time of day _____		
Leg cramps on walking or at night	□No	□Yes

Enlarged veins in legs	□No	□Yes
Recurrent stomach pain	□No	□Yes
Belching or heartburn	□No	□Yes
Is it relieved by food or medication	□No	□Yes
Describe your appetite:	□Good	□Fair □Poor
Nausea or vomiting	□No	□Yes
Avoid some foods	□No	□Yes
What kinds _____		
Avoid spices	□No	□Yes
Abdominal cramping	□No	□Yes
Color of bowel movement _____		
Any blood in bowel movement	□No	□Yes
Rectal pain with bowel movement	□No	□Yes
Change in size, shape or texture of bowel movement	□No	□Yes
Describe _____		
Pain on urinating	□No	□Yes
Difficulty in starting urination	□No	□Yes
Do you get up at night to urinate	□No	□Yes
How many times _____		
Urinate more than before	□No	□Yes
Urinate less than before	□No	□Yes
Any blood in urine	□No	□Yes
How many times per day do you urinate _____		
Full feeling of bladder, but only small amount of urination	□No	□Yes
Lose urine on coughing/sneezing	□No	□Yes
Discharge from penis	□No	□Yes
Recurrent back pains	□No	□Yes
Backaches	□No	□Yes
Joint pains	□No	□Yes
Swelling of any joints	□No	□Yes
Redness or heat of any joint	□No	□Yes
Tingling or weakness of hands or feet	□No	□Yes
Muscle Spasms	□No	□Yes
Loss or change in sensation of hands or feet	□No	□Yes
Trembling of any extremity	□No	□Yes
Growth in neck or throat	□No	□Yes
Hot flashes	□No	□Yes
Tiredness without apparent reason	□No	□Yes
Brittleness of nails	□No	□Yes
Dryness of skin	□No	□Yes
Easy bruising	□No	□Yes
Inability to stand heat	□No	□Yes
Inability to stand cold	□No	□Yes
Change in hair texture	□No	□Yes
Change in skin texture	□No	□Yes
Any skin rash	□No	□Yes

Clear all form fields.