

# MEDICAL HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Sex: \_\_\_\_\_

Race: \_\_\_\_\_

Health History of the Patient	Family History	Review of Systems (Have you recently had or now have)
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	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
Other Illness		

Explain all YES Answers:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgical Procedures (include approx. dates):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications and Dosage:

\_\_\_\_\_

\_\_\_\_\_

Allergies to Medicine \_\_\_\_\_

Date of Last Tetanus: \_\_\_\_\_

**Office Use:**

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other Illnesses		

Explain all YES Answers:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cause of death of parents, brothers and/or sisters:

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Most Recent Occupation: \_\_\_\_\_

History of Domestic Abuse?  
 Yes                       No

Are you:  
 Married                       Single  
 Divorced                       Widowed

Number of Children Living: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_

Presently Living Alone?  
 Yes                       No

Smoke (#) of \_\_\_\_\_ Packs per Day

Alcohol:     Never     Occasional  
 Moderate to Heavy

Drug Overuse:                       None  
 Presently                       Past Problem

	Yes	No
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills of Fever		
Heart or Chest Pain		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps with Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Frequent Belching		
Frequent Loose Bowel Movements		
Blood in Bowel Movements		
Frequent Constipation		
Hemorrhoids		
Frequent Urination (pass water)		
Burning on Urination		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Get Up Every Night to Urinate		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Hot or cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		
Women Only:		
Irregular Periods		
Vaginal Discharge		
Frequent Spotting		

Explain all YES Answers on Back:

**Advance Directive**

I DO                       I DO NOT

have an Advance Directive.

Type:

Living Will                       Durable POA

Agent's Name: \_\_\_\_\_