Medical History Form

Name____

Reason for consultation ____

Referring physician ____________________ **Primary care physician**_________________

Past Medical History

Check all that apply and list details/diagnoses

☐ **Myocardial Infarction** ☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Emphysema**

☐ **Irregular Heartbeat** ☐ **High Cholesterol** ☐ **Thyroid Problems** ☐ **Asthma**

☐ **Stroke** ☐ **Coagulation Disorder** **(you may take Plavix or Coumadin for)** ☐ **Heart Failure**

☐ **Sleep Apnea** ☐ **Cancer** ____

Other Medical Problems and details:

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MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, aspirin or blood thinners:

Medication	Dose	Times per day	Medication	Dose	Times per day

SURGICAL HISTORY: Including Defibrillators, Pacemakers or Stents

Operation	Date	Operation	Date

ALLERGIES or REACTIONS: ☐ **None** ☐ **Latex**

Medication	Reaction or Side Effect

FAMILY HISTORY:
Please check all that apply.

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other
Anesthesia Problem							
Asthma							
Bleeding Problems							
Breast Cancer							
Colon Cancer							
Melanoma							
Thyroid Cancer							
Parathyroid Cancer							
Prostate Cancer							
Diabetes							
Heart Attack							
High Blood Pressure							
Kidney Disease							
Leukemia							
Lupus							
Lymphoma							
Stroke							
Vascular Disease							

SOCIAL HISTORY
Tobacco Use
Cigarettes

☐ Never ☐ Current Smoker: packs/day _____ # of years _____

☐ Quit: Date _____ How many years did you smoke? _____

Other Tobacco:

☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use

☐ No ☐ Yes: # drinks/week _____

CURRENT SYMPTOMS CONTINUED

Genitourinary		
Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force or strain with urination	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Painful periods	no	yes
Irregular periods	no	yes
Vaginal discharge	no	yes

Hematologic/Lymphatic		
Slow to heal after cuts	no	yes
Easily bruise or bleed	no	yes
Anemia	no	yes
Phlebitis	no	yes
Transfusion	no	yes
Swollen glands	no	yes

PLEASE INDICATE BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional		
Does your job require heavy lifting	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Eyes and vision		
Eye disease or injury	no	yes
Wear glasses or contact lenses	no	yes
Blurred or double vision	no	yes
Glaucoma	no	yes
Ears, nose, throat		
Hearing loss	no	yes
Ringing in the ears	no	yes
Earaches or drainage	no	yes
Sinus problems	no	yes
Nose bleeds	no	yes
Mouth sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes
Heart and Cardiovascular		
Heart trouble	no	yes
Chest pains	no	yes
Sudden heartbeat changes	no	yes
Swelling of feet, ankles, hands	no	yes
Respiratory		
Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes
Gastrointestinal		
Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful bowel movements or constipation	no	yes
Blood in stool	no	yes
Stomach pain	no	yes

Musculoskeletal		
Joint Pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles/joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Difficulty in walking	no	yes
Skin and Breasts		
Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes
Neurological		
Frequent or recurrent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensations	no	yes
Tremors	no	yes
Paralysis	no	yes
Stroke	no	yes
Head injury	no	yes
Psychiatric		
Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Sleep problems	no	yes
Endocrine		
Glandular or hormone problem	no	yes
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Dry skin	no	yes
Change in hat or glove size	no	yes