MEDICAL HISTORY

NAME _____ **AGE**_____ **HEIGHT**_____**WEIGHT**_____

PRIMARY CARE DOCTOR_____ REFERRED BY DR _____

ALLERGIES TO MEDICATIONS_____**ALLERGIC TO LATEX?** Y N

What are your concerns for today's visit?_____

Have you had this problem before? _____ Is this the result of an injury? _____ Date of injury?_____

PREVIOUS HOSPITAL STAYS/SURGERIES (Include tonsils and ear tubes)_____

_____

_____

MEDICATIONS YOU ARE TAKING (amounts, times per day) (include aspirin, antacids, birth control, herbals, cold, sinus, allergy)_____

_____

DO YOU HAVE/HAD ANY OF THE FOLLOWING? If **yes**, *please circle those that apply:*

Allergies	Cancer	Fainting	Hearing Loss	Kidney Disease	Stroke
Asthma	Diabetes	Hay Fever	Heart Disease	Liver Disease	Thyroid Disease
Bleeding Problems	Dizziness	Headaches	Hypertension	Rheumatoid Arthritis	Tuberculosis

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT? _____

_____

_____

WOMEN ONLY: Are you pregnant?_____ Month of gestation?_____

REVIEW OF SYSTEMS Write YES if part of CURRENT problem or CHECK (√) if you have these SYMPTOMS:

Chest Pain_____	Cough _____	Daytime Sleepiness____	Ear Pain Itch_____	Joint Pain_____
Irregular Heart Rate_____	Hoarseness_____	Insomnia_____	Sinus Pressure/Pain_____	Muscle Pain_____
Heartburn_____	Throat Clearing_____	Fatigue_____	Sneezing_____	Skin rash/New Lesion_____
Shortness of Breath_____	Throat Dryness/Itch_____	Vision Problems_____	Post Nasal Drip_____	Swollen Glands/Lymph Nodes___
Weight loss or gain_____	Snoring/Sleep Disturb____	Depression_____	Watery/itchy eyes_____	Problems with Urination_____

SOCIAL HISTORY

What is your occupation? _____

TOBACCO HISTORY (ie, smoke, chew, etc.) Yes_____ No ____ How often? _____ If you have quit, how long ago? _____

ALCOHOL USE? Yes ____ No _____ How often? _____ If you have quit, how long ago?_____

FAMILY HISTORY: Enter relationship name (i.e.; brother, mother).

Problems with

Anesthesia: _____ Heart Disease: _____Cancer:_____ Hearing Loss:_____ Asthma:_____

Allergies:_____ Bleeding Problem:_____Diabetes:_____ Migraines:_____ Stroke:_____

I represent the information provided in this form is true, accurate and complete.

Signature_____ Date_____