

MEDICAL HISTORY INFORMATION SHEET

NAME: _____ **AGE:** _____ **TODAY'S DATE:** ____/____/____

Birth Date: (M / D / Year) ____/____/____ **Height** ____ft ____inches **Weight** _____lbs

REASON FOR TODAY'S EXAM _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

- | | | | |
|-----------------------|---------------------|--------------------|-------------------------|
| High Blood Pressure | DVT | Lung Disease | Stroke |
| High Cholesterol | Pulmonary Embolus | Asthma | Diabetes |
| Vein Trouble | Tuberculosis | Heart Trouble | Pneumonia |
| Kidney Disease | Nervous Disorder | Seasonal Allergies | HIV |
| Thyroid Problems | Sinus | Arthritis | Hepatitis |
| Drug Abuse/Alcoholism | Tonsillitis | Gastrointestinal | Osteoporosis |
| Joint Replacement | Bleeding Tendencies | Cancer: | If Yes, What Type _____ |

Other: _____
History of Serious Injuries / Illnesses? YES NO If yes, please describe below.

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

- | | | | |
|-------------------------------|---------------------------|--------------------------|--------------------|
| High Blood Pressure _____ | DVT _____ | Lung Disease _____ | Stroke _____ |
| High Cholesterol _____ | Pulmonary Embolus _____ | Asthma _____ | Diabetes _____ |
| Vein Trouble _____ | Tuberculosis _____ | Heart Trouble _____ | Pneumonia _____ |
| Kidney Disease _____ | Nervous Disorder _____ | Seasonal Allergies _____ | HIV _____ |
| Liver Disease _____ | Seizures _____ | Ear Problems _____ | Sinus _____ |
| Drug Abuse / Alcoholism _____ | Thyroid Problems _____ | Arthritis _____ | Tonsillitis _____ |
| Joint Replacement _____ | Hepatitis _____ | Gastrointestinal _____ | Osteoporosis _____ |
| Cancer: Type _____ | Bleeding Tendencies _____ | | |

Other: _____

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____ Children: Yes No Live Alone: Yes No
Tobacco Use: Never In the Past Presently How Much? _____ How Long? _____
Alcohol Use: Daily Occasional None Other substance use or abuse? Yes No

SYSTEM REVIEW: Please describe any active problem or symptom.

- General Symptoms (i.e. fever, weight gain/loss, fatigue) _____
- | | | |
|------------------------------------|----------------------------|-------------------|
| Eyes/Ears/Nose/Throat _____ | Heart _____ | Lung _____ |
| Allergies/Rashes _____ | Muscles/Bones/Joints _____ | Psychiatric _____ |
| Endocrine (Diabetes/Thyroid) _____ | Bleeding/Lymph Nodes _____ | Nerves _____ |
| Skin and/or Breasts _____ | OB/Genital/Urinary _____ | Abdomen _____ |

ALLERGIC TO LATEX: Yes No ALLERGIC TO MEDICATIONS: Yes No

PLEASE LIST: _____

CURRENT MEDICATIONS: _____