PATIENT MEDICAL HISTORY

NAME: _____ DOB: _____

MARITAL STATUS: Single Married Widowed Divorced

FEMALE PATIENTS:

Age of Menstruation: _____ Date of Last Period: _____

Of Pregnancies: _____ # of Births: _____

Age Of Menopause: _____

Please indicate if you are having, or have had any of the following problems:

HEART	MUSCULOSKELETAL	RESPIRATORY	ENDOCRINE
☐ Coronary Artery Disease ☐ Hypertension ☐ High Cholesterol ☐ Heart Murmur ☐ Heart Failure ☐ Heart Attack ☐ Other	☐ Osteoarthritis ☐ Osteoporosis ☐ Chronic Muscle Pain ☐ Swollen Joints ☐ Bone/Joint Pain ☐ RA ☐ Fibromyalgia ☐ Other	☐ Asthma ☐ Emphysema ☐ Sleep Apnea ☐ Shortness of Breath ☐ Chest Pain ☐ Other	☐ Thyroid Disease ☐ Diabetes ☐ Excessive Weight Loss ☐ Excessive Weight Gain ☐ Other
NEURO	**VASCULAR**	**HEENT**	**URINARY**
☐ Numbness ☐ Memory Loss ☐ Seizure Disorder ☐ Tremors Stroke ☐ Other	☐ Phlebitis ☐ Clotting / Bleeding Problems ☐ Easy Bruising ☐ Anemia ☐ Other	☐ Blurry Vision ☐ Hearing Loss ☐ Ringing in Ears ☐ Pain with Swallowing ☐ Other	☐ Frequent Burning ☐ Blood in Urine ☐ Kidney Stone ☐ Other
SKIN	**GASTROINTESTINAL**	**PSYCHIATRIC**	**GENERAL**
☐ Rash ☐ Psoriasis ☐ Lesions ☐ Moles ☐ Other	☐ Reflux ☐ Peptic Ulcer ☐ Hepatitis ☐ Gallstones ☐ Changes in Bowels ☐ Other	☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ ADHD ☐ Other	☐ Cancer _____ ☐ Fever ☐ Chills ☐ Night sweats ☐ HIV ☐ TB ☐ Other ☐ Other_____
GENITALS / BREAST			
☐ Nipple Discharge ☐ Menopause ☐ Other			

PLEASE LIST ALL CURRENT MEDICAL PROBLEMS:

1. 5.
2. 6.
3. 7.
4. 8.

Please Indicate Your Current Use Of:

ALCOHOL: _____

CIGARETTES: _____

COFFEE/TEA: _____

PATIENT HISTORY & PHYSICAL – PAGE 2

FAMILY HISTORY:

RELATIVE	AGE	DECEASED?	MEDICAL PROBLEMS
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/Sister			

ARE THERE ANY CANCERS IN YOUR FAMILY? IF SO, WHO? AND WHAT TYPE?

PLEASE LIST ALL MEDICATIONS:

MED NAME	DOSE	HOW MANY PILLS?	HOW OFTEN?

PLEASE LIST ALL OPERATIONS:

YEAR	OPERATION

PLEASE LIST ALL MEDICATION ALLERGIES:

DRUG NAME	REACTION