MEDICAL HISTORY INFORMATION SHEET

Name: _____ Age: _____ Today's Date:_____/_____/_____

Date of Birth: _____/_____/_____ Height: _____ft_____in Weight: _____lbs

Reason for today's visit: _____

Past Medical History - Please check any illnesses/conditions which YOU have had:

□ High Blood Pressure □ DVT □ Lung Disease □ Stroke

□ High Cholesterol	□ Pulmonary Embolism	□ Osteoporosis	□ Diabetes
□ Vein Trouble	□ Tuberculosis	□ Heart Trouble	□ Pneumonia
□ Kidney Disease	□ Nervous Disorder	□ Seasonal Allergies	□ HIV
□ Thyroid Problems	□ Sinus Problems	□ Arthritis	□ Hepatitis
□ Drug Abuse/Alcoholism	□ Tonsillitis	□ Blood Disorders	□ Asthma
□ Joint Replacement	□ Gastrointestinal	□ Cancer: _____	

Other:_____

History of Serious Injuries/Illnesses: Yes □ No □

If yes, please describe: _____

Surgical History and/or Surgical Complications: _____

_____

Family Medical History - Please check any illnesses/conditions immediate FAMILY has had:

–Please be sure to list which family member–

□ High Blood Pressure_____ □ DVT_____ □ Lung Disease_____

□ High Cholesterol_____ □ Pulmonary Embolism_____ □ Osteoporosis_____

□ Vein Trouble_____ □ Tuberculosis_____ □ Heart Trouble_____

□ Kidney Disease_____ □ Nervous Disorder_____ □ HIV_____

□ Thyroid Problems_____ □ Stroke_____ □ Arthritis_____

□ Drug Abuse/Alcoholism_____ □ Diabetes_____ □ Blood Disorders_____

□ Joint Replacement_____ □ Gastrointestinal_____ □ Asthma_____

□ Hepatitis_____ □ Cancer: _____

Other:_____

Social History:

Occupation:_____ Marital Status:_____ Children: □ Yes □ No Live Alone: □ Yes □ No

Tobacco Use: □ Never □ In the Past □ Presently How Much?_____

Alcohol Use: □ Daily □ Occasional □ None Other substance use or abuse? □ Yes □ No

System Review - Please describe any active problems or symptoms:

General Symptoms (i.e. fever, weight gain/loss, fatigue):_____

Eyes/Ears/Nose/Throat:_____ Heart:_____ Lung:_____

Allergies/Rashes:_____ Muscles/Bones/Joints:_____ Psychiatric:_____

Endocrine (Diabetes/Thyroid):_____ Nerves:_____ Bleeding/Lymph Nodes:_____

Skin and/or Breasts:_____ OB/Genital/Urinary:_____ Abdomen:_____

Allergic to latex: □ Yes □ No Allergic to Medications: □ Yes □ No

Please List with Reaction:_____

_____

Current Medications:

_____

_____

_____