MEDICAL HISTORY

Patient's Name: _____

Purpose of Visit: _____

Height: _____ Weight: _____ Date of Last Physical: _____

Primary Care Physician: _____ Referring Physician: _____

X-Rays or Lab Work Done: Y _____ N _____ Where? _____

List All Past and Current Medical Conditions: _____

_____

_____

List All Surgeries or Procedures, and the Year: _____

_____

_____

Current Medications with Dose and Frequency (**include over-the-counter medications, vitamins, herbs, etc**):

Name of Medication	Dosage	Frequency

Drug Allergies: _____

Type of Work You Do: _____

Who's Accompanying You Today? _____ Who Lives With You? _____

Do You Smoke: Y _____ N _____ If you smoke(d): _____ Packs per day for _____ Year(s). Year You Quit _____

All tobacco products cause disease and the impact of smoking on surgical patients is considerable. _____
(please initial)

If You Drink Alcohol: _____ drinks per day/week (circle one)

If Under 18 Years Old: Grade in School: _____ Are Your Immunizations Up to Date? Y _____ N _____

List Any Illnesses That Run in Your Family: _____

Parents Age & Health (If deceased, age at death & cause): Father _____ Mother _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY:

OVER FOR PAGE 2

PATIENT'S HEALTH HISTORY PART 2

Patient's Name:_____

Review of Systems: Have you ever been treated by a physician for any of the following? Please answer **all** questions.
Check "Y" for Yes or "N" for No. **Explain "Yes" answers at the bottom of this page and write the year diagnosed / treated.**

General:
Y__N__ Weight Lose _____lbs
Y__N__ Weight Gain _____lbs
Last Tetanus shot: (year)_____.

Eyes:
Y__N__ Glaucoma
Y__N__ Cataracts
Y__N__ Recent vision changes

Ears/nose/mouth/throat:
Y__N__ Hearing loss
Y__N__ Nose bleeds
Y__N__ Gum problems
Y__N__ Sore throat
Y__N__ Hoarseness
Y__N__ Trouble swallowing

Cardiovascular:
Y__N__ High blood pressure
Y__N__ Heart attack
Y__N__ Heart catheterization
Y__N__ Chest pain
Y__N__ Irregular heart beat
Y__N__ Shortness of breath
Y__N__ Feet / leg swelling
Y__N__ Varicose veins

Respiratory:
Y__N__ Cough
Y__N__ Trouble breathing
Y__N__ Wheezing
Y__N__ Asthma
Y__N__ Bronchitis

Endocrine:
Y__N__ Diabetes
Y__N__ Thyroid problems

Gastrointestinal:
Y__N__ Abdominal pain
Y__N__ Hepatitis
Y__N__ Ulcers
Y__N__ Heartburn
Y__N__ Constipation
Y__N__ Diarrhea
Y__N__ Blood in stool
Y__N__ Colonoscopy year_____
Y__N__ Flex sig. year _____
Last stool occult blood test/year_____

Urinary:
Y__N__ Painful urination
Y__N__ Slow/frequent urination
Y__N__ Infections
Y__N__ Blood in urine
Y__N__ Kidney stones

Musculoskeletal:
Y__N__ Hernias
Y__N__ Fractures/dislocations
Y__N__ Arthritis
Y__N__ Muscle pain/cramps

Skin:
Y__N__ Rashes/dermatitis
Y__N__ Changes in moles

Hematologic/lymphatic:
Y__N__ Easy bleeding or bruising
Y__N__ Anemia
Y__N__ Blood transfusion/year___
Y__N__ Swollen lymph nodes

Immunologic:
Y__N__ HIV / AIDS
Y__N__ Hepatitis (A, B or C?)

Neurologic:
Y__N__ Headaches
Y__N__ Weakness
Y__N__ Dizziness
Y__N__ Numbness / tingling
Y__N__ Seizures
Y__N__ Strokes

Psychiatric:
Y__N__ Depression
Y__N__ Trouble sleeping
Y__N__ Schizophrenia
Y__N__ Alcohol dependency
Y__N__ Drug dependency

Men Only:
Y__N__ Prostate disease
Y__N__ Testicular lumps, pain
Y__N__ Venereal disease

Women Only:
Last menstrual period started_____
Number of pregnancies:_____
Number of deliveries:_____
Last Pap smear (date)_____
Y__N__ menstrual irregularities
Y__N__ Menopause, age? _____
Y__N__ Vaginal discharge
Y__N__ Venereal disease

Breast:
Last Mammogram (date)_____
Y__N__ Monthly self exams
Y__N__ Lumps
Y__N__ Nipple discharge
Y__N__ Pains

Additional details about your health history