

**CONFIDENTIAL
MEDICAL
HISTORY**

Patient's Name _____ Date _____

Name: _____

Describe your symptoms or complaints:

Is your problem due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe your accident:

Are you under another Doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dr's name: For what reason?
Dr's name: For what reason?
Dr's name: For what reason?

What drugs are you allergic to?

What medicines do you take for your present problem?	Dosage	What other medicines or drugs do you take?	Dosage
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

What operations have you had?	When?	Operations?	When?
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

How much do you smoke? _____	How much alcohol do you drink? _____
What do you smoke? _____	What alcohol do you drink? _____
When did you quit smoking? _____	When did you quit drinking? _____

DO YOU HAVE OR HAVE YOU HAD THESE CONDITIONS? Name: _____

- CONSTITUTIONAL**
- Arthritis/gout Yes No
 - Recent weight change Yes No
 - Insomnia Yes No
 - Fatigue Yes No
 - Cancer Yes No
 - HIV/AIDS..... Yes No
 - Hepatitis..... Yes No
 - Tuberculosis (TB)..... Yes No

- EYES**
- Eye disease or injury Yes No
 - Wear glasses/contact lens Yes No
 - Blurred or double vision Yes No
 - Glaucoma Yes No

- EAR/NOSE/MOUTH/THROAT**
- Hearing Loss Yes No
 - Ringing Yes No
 - Sinus problem Yes No
 - Voice change Yes No
 - Swollen glands in neck Yes No

- CARDIOVASCULAR**
- Heart trouble Yes No
 - Chest pain or angina Yes No
 - Palpitation Yes No
 - Shortness of breath Yes No
 - Hypertension Yes No

- NEUROLOGICAL**
- Frequent or recurring headaches Yes No
 - Light headed or dizzy Yes No
 - Convulsions or seizures Yes No
 - Memory loss or confusion Yes No
 - Tremors Yes No
 - Paralysis Yes No
 - Stroke Yes No
 - Head Injury Yes No

- PSYCHIATRIC**
- Nervousness Yes No
 - Depression Yes No
 - Anxiety Yes No

- ENDOCRINE**
- Glandular or hormone problem Yes No
 - Thyroid disease Yes No
 - Diabetes Yes No

- RESPIRATORY**
- Chronic or frequent coughs Yes No
 - Spitting up blood Yes No
 - Shortness of breath Yes No
 - Asthma or wheezing Yes No

- GASTROINTESTINAL**
- Loss of appetite Yes No
 - Rectal bleeding or blood in stool Yes No
 - Abdominal pain or heartburn Yes No
 - Peptic ulcer (stomach or duodenal) Yes No

- GENITOURINARY**
- Frequent urination Yes No
 - Burning or painful urination Yes No
 - Blood in urine Yes No
 - Incontinence or dribbling Yes No
 - Kidney stones Yes No
 - Sexual difficulty Yes No

- MUSCULOSKELETAL**
- | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|
| | | Right | Left |
| Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Back Pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have numbness anywhere? Yes No Describe where:

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

ADDITIONAL MEDICAL HISTORY