# CONFIDENTIAL MEDICAL HISTORY

Patient's Name _____ Date _____

**Name:** _____

| Describe your symptoms or complaints: |
|---|
| |
| |
| |
| |
| |

| Is your problem due to an accident? ❑ Yes ❑ No Describe your accident: |
|---|
| |
| |
| |
| |
| |

| Are you under another Doctor's care? ❑ Yes ❑ 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: _____

| | Yes | No |
|---|---|---|
| **CONSTITUTIONAL** | | |
| Arthritis/gout | ❑ | ❑ |
| Recent weight change | ❑ | ❑ |
| Insomnia | ❑ | ❑ |
| Fatigue | ❑ | ❑ |
| Cancer | ❑ | ❑ |
| HIV/AIDS | ❑ | ❑ |
| Hepatitis | ❑ | ❑ |
| Tuberculosis (TB) | ❑ | ❑ |
| **EYES** | | |
| Eye disease or injury | ❑ | ❑ |
| Wear glasses/contact lens | ❑ | ❑ |
| Blurred or double vision | ❑ | ❑ |
| Glaucoma | ❑ | ❑ |
| **EAR/NOSE/MOUTH/THROAT** | | |
| Hearing Loss | ❑ | ❑ |
| Ringing | ❑ | ❑ |
| Sinus problem | ❑ | ❑ |
| Voice change | ❑ | ❑ |
| Swollen glands in neck | ❑ | ❑ |
| **CARDIOVASCULAR** | | |
| Heart trouble | ❑ | ❑ |
| Chest pain or angina | ❑ | ❑ |
| Palpitation | ❑ | ❑ |
| Shortness of breath | ❑ | ❑ |
| Hypertension | ❑ | ❑ |
| **NEUROLOGICAL** | | |
| Frequent or recurring headaches | ❑ | ❑ |
| Light headed or dizzy | ❑ | ❑ |
| Convulsions or seizures | ❑ | ❑ |
| Memory loss or confusion | ❑ | ❑ |
| Tremors | ❑ | ❑ |
| Paralysis | ❑ | ❑ |
| Stroke | ❑ | ❑ |
| Head Injury | ❑ | ❑ |
| **PSYCHIATRIC** | | |
| Nervousness | ❑ | ❑ |
| Depression | ❑ | ❑ |
| Anxiety | ❑ | ❑ |
| **ENDOCRINE** | | |
| Glandular or hormone problem | ❑ | ❑ |
| Thyroid disease | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| **RESPIRATORY** | | |
| Chronic or frequent coughs | ❑ | ❑ |
| Spitting up blood | ❑ | ❑ |
| Shortness of breath | ❑ | ❑ |
| Asthma or wheezing | ❑ | ❑ |
| **GASTROINTESTINAL** | | |
| Loss of appetite | ❑ | ❑ |
| Rectal bleeding or blood in stool | ❑ | ❑ |
| Abdominal pain or heartburn | ❑ | ❑ |
| Peptic ulcer (stomach or duodenal) | ❑ | ❑ |

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

| **MUSCULOSKELETAL** | | | Right | Left |
|---|---|---|---|---|
| Arm Pain | ❑ | ❑ | ❑ | ❑ |
| Leg Pain | ❑ | ❑ | ❑ | ❑ |
| Arm Weakness | ❑ | ❑ | ❑ | ❑ |
| Leg Weakness | ❑ | ❑ | ❑ | ❑ |
| Neck Pain | ❑ | ❑ | ❑ | ❑ |
| Upper Back Pain | ❑ | ❑ | ❑ | ❑ |
| Low Back Pain | ❑ | ❑ | ❑ | ❑ |

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