

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**YOUR MEDICAL HISTORY**

<p><input checked="" type="checkbox"/> <b>Have you EVER had?</b></p> <p><b>General</b></p> <p>Weight loss or gain Fatigue, Change in appetite Fever or night sweats</p> <p><b>Skin</b></p> <p>Rashes Growths, Itching Change in mole or wart</p> <p><b>Eyes</b></p> <p>Change in Vision Itching or drainage</p> <p><b>Nose</b></p> <p>Discharge, frequent bleeds Obstruction</p> <p><b>Throat</b></p> <p>Pain, hoarseness, difficulty swallowing</p>	<p>Dental appliances</p> <p><b>Cardiovascular</b></p> <p>Chest pain, palpitation Loss of consciousness Swelling, heart murmur</p> <p><b>Respiratory</b></p> <p>Cough, Wheezing Shortness of breath</p> <p><b>Gastrointestinal</b></p> <p>Nausea Vomiting of blood Change in bowel habits Diarrhea, Constipation</p> <p><b>Genitourinary</b></p> <p>Pain on urination Blood in urine, Frequency</p>	<p>Urgency of urination Incontinence</p> <p><b>Neuro</b></p> <p>Balance problems Weakness, sensory changes to face</p> <p><b>Endocrine</b></p> <p>Heat/cold balance, Diabetes, Goiter Tremors, Hormone therapy or replacement</p> <p><b>Hem-Lymph</b></p> <p>Easy bruising, Prolonged bleeding Swollen glands, Extremity swelling</p> <p><b>Immune</b></p> <p>Recent Chemo or Radiation therapy Immune suppressant drugs Steroids, Cyclosporins, Methotrexate</p>
--	--	---

Have you had?	Yes	No	Date	Treating Physician	Current Medications: Drug	Prescribing Physician
Diabetes						
Tuberculosis						
Allergic disease						
Kidney disease						
High blood pressure						
Heart disease						
Hepatitis: Type: A B C C						
Asthma/COPD/Emphysema						
Cancer						
If "Yes", type:						
Radiation treatments?						
Chemotherapy?						
Hypo/hyperthyroidism						
GERD						
Ulcer						
Bleeding disorders						
Problems w/anesthesia						
Sleep Apnea - on CPAP?						
Significant childhood illness						
Other:						
<b>Orthopedic Conditions</b>	<b>Yes</b>	<b>No</b>				
Sprain, fracture, dislocation						
Laceration (nerve / tendon)						
Back injury						
Neck Injury						
Scoliosis						
Other:						

Allergies / Reaction:

---

Do you smoke? Yes No Packs per day \_\_\_\_\_  
 Marital status:  Married  Single  
 Widowed  Separated  Divorced  
 Occupation: \_\_\_\_\_  
 Education (opt): \_\_\_\_\_  
 Recreational activities: \_\_\_\_\_

Your Surgical History:					Non-Surgical Hospitalizations:	
Have you had?	Yes	No	Date	Treating Physician	Date	Reason/Name of hospital
Tonsillectomy						
Appendectomy						
Hysterectomy						
Hernia repair						
Heart Surgery						
Gall bladder surgery						
Orthopedic surgery						
(cont)						
Other						

Family Medical History	If Living		If Deceased		Has any blood relative ever had:	Yes	No	Who?
	Age	Health	Age at Death	Cause				
Father					Diabetes			
Mother					Tuberculosis			
Brother/Sister	1				Cancer			
	2				Allergic disease			
	3				Kidney disease			
	4				High blood pressure			
	5				Heart disease			
Spouse					Asthma/bronchitis			
Son/Daughter	1				Bleeding disorders			
	2				Problems w/ anesthesia			
	3				Who is your regular Doctor?			

### Review of Systems & Medical History

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Physician Signature