PATIENTS MEDICAL HISTORY

DATE:_____

1. FULL NAME:_____
2. Describe briefly your reason for coming to my office: (date of injury, if applicable):_____
   _____
   _____
   _____

GENERAL HEALTH

1. Are you allergic to any foods? □Yes □ No
   if so, list foods & type of reaction:_____
2. Are you allergic to any medication: □ Yes □No if so, list medication & type of reaction:_____
3. Do you have any other allergies such as creams, tape, latex, ect?□ Yes □ No
   if so, please list:_____

CURRENT MEDICATIONS

(Include herbs, vitamins, aspirin,Advil, anti-inflammatory's & any other over-the-counter medications. Provide a separate sheet if necessary)

MEDICATION	STRENGTH	DOSAGE	FREQUENCY	REASON

PAST MEDICAL HISTORY

Do you bruise or BLEED EASILY? □ Yes □No

4. Are you being treated for any health problems now or have you been treated with in the past five years? □ Yes □ No

   if so, What type of illness _____

   _____

5. Have you ever been treated for one of the following:

	Yes	No		Yes	No
Diabetes			HIV/AIDS		
Tuberculosis			Liver Disease or Hepatitis		
Kidney Disease			Blood or Bleeding problem		
High Blood Pressure			Cancer		
Heart or Circulatory Disease			Arthritis		
Heart Attack			Epilepsy or seizures		
Lung problems or pneumonia			Sleep Apnea requiring a mask		
Thyroid Problem			Psychological or Emotional problems		

6. Do you ever experience one of the following:

	Yes	No		Yes	No
Cough up blood			Have Stomach problems		
Vomit up blood/blood in stools			Feel faint or dizzy		
Have shortness of breath			Have nose problems (runny or stuffy)		
Have chest pain			Have dry eyes		
Have heart palpitations			Have problems w/healing		
Have skin Disorders					

Please explain all yes answers: _____

_____

_____

7. Please list any operations you have had, including dates: _____
_____
_____
_____

8. Have you had any major injuries? □Yes □ No When:_____How injured:_____
_____Nature of Injury:_____

9. Where &When was your last mammogram? _____

10. Where & When was your last EKG? _____

11. Present weight: _____ Weight one year ago:_____Best weight for you:_____Height:_____

SOCIAL HISTORY

1. Marital Status: _____
2. How many children do you have: _____
3. Tobacco use? □Yes □No Smoke□ Chew □ How much per day? _____
   When did you start?_____How long did you smoke? _____When did you quit? _____
4. What type of work do you do_____
5. Do you drink alcohol?_____How much & how often? _____ When was you last drink?_____
6. Any history of IV drug use? □ Yes □ No

FAMILY HISTORY

	Yes	No	Who		Yes	No	Who	
Coronary artery disease					Melanoma			
Heart Attack					Breast Cancer			
Malignant Hyperthermia					Skin Diseases			
Skin Cancer								