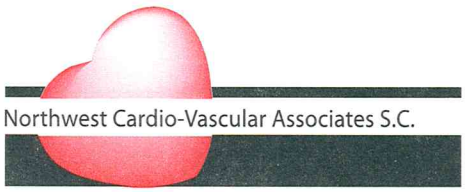
(FOR OFFICE USE ONLY)
DATE OF FIRST APPOINTMENT
_____



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PATIENT MEDICAL HISTORY

Patient's Full Name: _____ Date of Birth: _____AGE_____
☐ Male ☐ Female

Full Name Of
Referring Physician: _____

Referring Physician's
Phone # _____

Fax # _____

What are your current health complaints? _____

_____

Please list any medications you are currently taking:

NAME OF MEDICATION	DOSAGE	How often do you take this medication?

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily _____
Use of Tobacco: ☐ Never ☐ Previously But Quit ☐ Current Packs Per Day _____
Use of Drugs: ☐ Never ☐ Type/Frequency _____

Please list any known allergies, the reactions or side effects.

_____

_____

Have you had any surgeries (List Type) Year of Surgery

_____ _____

_____ _____

_____ _____

PLEASE TURN OVER

Have you experienced any of the following?

PLEASE ANSWER ALL QUESTIONS

CARDIOVASCULAR

Date

Chest Pain	No	Yes
Palpitations	No	Yes
Heart Attack	No	Yes
Pacemaker/Defibrillator	No	Yes
Shortness of Breath	No	Yes
Swelling of Feet	No	Yes
Fainting Episode/Disorder	No	Yes
Lightheadedness	No	Yes
Pain in Legs with Walking	No	Yes
Varicose Veins	No	Yes
Heart Murmur	No	Yes
Rheumatic Fever	No	Yes
High Cholesterol	No	Yes
Hypertension	No	Yes

CONSTITUTIONAL

Recent Weight Gain/Loss	No	Yes
Fever	No	Yes
Arthritis/Gout	No	Yes

EYES

Eye Disease or Injury	No	Yes
Wear Glasses/Contact Lens	No	Yes
Blurred or Double Vision	No	Yes
Glaucoma	No	Yes

ENT

Hearing Loss	No	Yes
Ringing in the Ears	No	Yes
Nose Bleeds	No	Yes
Bleeding Gums	No	Yes

RESPIRATORY

Frequent Coughing	No	Yes
Spitting up Blood	No	Yes
Asthma or Wheezing	No	Yes
COPD	No	Yes

GASTROINTESTINAL

Loss of Appetite	No	Yes
Change in Bowel Movements	No	Yes
Nausea or Vomiting	No	Yes
Blood in Stool	No	Yes
Stomach Pain	No	Yes
Liver Disorders/Hepatitis	No	Yes

GENITOURINARY

Date

Prostate Problems	No	Yes
Frequent Urination	No	Yes
Frequent Burning or Painful Urination	No	Yes
Blood in Urine	No	Yes
Kidney Stones or Problems	No	Yes

MUSCULOSKELETAL

Joint Pain or Swelling	No	Yes
Weakness of Muscles or Joints	No	Yes
Muscle Pain or Cramps	No	Yes
Back Pain	No	Yes
Cold Extremities	No	Yes

SKIN

Rash or Itching	No	Yes
Change in Hair and Nails	No	Yes

NEUROLOGICAL

Stroke	No	Yes
Frequent or Recurring Headaches	No	Yes
Convulsions or Seizures	No	Yes
Numbness or Tingling Sensations	No	Yes
Tremors	No	Yes

PSYCHIATRIC

Memory Loss or Confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep Problems	No	Yes

ENDOCRINE

Glandular or Hormone Problem	No	Yes
Thyroid Disease	No	Yes
Heat or Cold Intolerance	No	Yes
Diabetes	No	Yes

HEMATOLOGIC/ONCOLOGY

Cancer What Type _____	No	Yes
Easily Bruise or Bleed	No	Yes
Anemia	No	Yes
Leg Vein Clots	No	Yes
Past Transfusion	No	Yes
Enlarged Glands	No	Yes

FAMILY HISTORY: (CHECK THE BOX(ES) THAT APPLY.)

FAMILY MEMBER	LIVING / AGE	DECEASED / AGE	HEART DISEASE	HIGH BLOOD PRESSURE	DIABETES	CANCER	OTHER (PLEASE LIST)
FATHER:							
MOTHER:							
SISTERS/BROTHERS:							
SISTERS/BROTHERS:							
SISTERS/BROTHERS:							
SISTERS/BROTHERS:							
SISTERS/BROTHERS:							
AUNTS/UNCLES:							
AUNTS/UNCLES:							
AUNTS/UNCLES:							
AUNTS/UNCLES:							
AUNTS/UNCLES:							
GRANDPARENTS:							
GRANDPARENTS:							
GRANDPARENTS:							
GRANDPARENTS:							
SONS/DAUGHTERS:							
SONS/DAUGHTERS:							
SONS/DAUGHTERS:							
SONS/DAUGHTERS:							