

## PATIENT MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  Retired  Homemaker  Unemployed  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Do you smoke? (Circle) Yes No How many packs a day? \_\_\_\_\_  
 Do you drink alcohol? (Circle) Yes No How many drinks a week? \_\_\_\_\_  
 Are you pregnant? (Circle) Yes No

Have you **EVER** been diagnosed or treated for:  **NO MEDICAL PROBLEMS**

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Cancer Which type?
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> GI bleed
<input type="checkbox"/> Other – Please state:		

What **MEDICATION(S)** do you take? (Write **clearly**)

**NOT TAKING ANY MEDICATIONS**

1.	4.
2.	5.
3.	6.

Have you **EVER** taken any of the following medications? (Circle all that apply)

Aspirin	Relafen	Celebrex	Excedrin	Ibuprofen (Motrin)
Mobic	Naprosyn (Alleve)	Voltaren	Tylenol	Limbrel

Have you ever had any previous **SURGERIES**?

**HAVE HAD NO SURGERIES**

Type of Surgery	When?
1.	
2.	
3.	
4.	

Do you have any **ALLERGIES** to the following medications or items?

**HAVE NO ALLERGIES**

Medication/Item	Reaction it causes
<input type="checkbox"/> Penicillins (Amoxicillin, Augmentin)	
<input type="checkbox"/> Cephalosporins (Keflex, Anacef)	
<input type="checkbox"/> Sulfa (Bactrim, Septra)	
<input type="checkbox"/> Mycins (Erythromycin, Clindamycin)	
<input type="checkbox"/> Latex (rubber gloves)	
<input type="checkbox"/> Dye (Gad, Iodine)	
<input type="checkbox"/> Other – Please state:	

Do you have **CLOSE RELATIVES** with any of the following conditions?

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart attacks	<input type="checkbox"/> Thyroid disease or Goiter	<input type="checkbox"/> Dupuytren's Disease
<input type="checkbox"/> Strokes	<input type="checkbox"/> Cancer (which kind?)	<input type="checkbox"/> Osteoporosis

Have you experienced any of the following within the last **THREE MONTHS**?

**HAVE HAD NONE OF SYMPTOMS BELOW**

<b>General</b> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue	<b>Hematologic</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Tendency to bruise or bleed easily <input type="checkbox"/> Previous blood transfusions <input type="checkbox"/> Blood clots in legs
<b>Cardiovascular</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swollen feet/legs <input type="checkbox"/> Difficulty breathing while lying in bed <input type="checkbox"/> Pain in legs while walking	<b>Integumentary</b> <input type="checkbox"/> Rashes or spots <input type="checkbox"/> Sudden changes in moles or growths <input type="checkbox"/> Itching or redness <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Abnormal hair or nail growth
<b>Endocrine</b> <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Sudden weight gain or loss <input type="checkbox"/> Frequent urination <input type="checkbox"/> Increased hat or glove sizes <input type="checkbox"/> Unusual changes in skin color	<b>Musculoskeletal</b> <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Limited joint motion <input type="checkbox"/> Abnormal masses or bumps
<b>Gastrointestinal</b> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody stools <input type="checkbox"/> Black or tarry stools <input type="checkbox"/> Hepatitis <input type="checkbox"/> Jaundice <input type="checkbox"/> Gallstones	<b>Neurological</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden weakness <input type="checkbox"/> Tremors <input type="checkbox"/> Memory loss <input type="checkbox"/> Unusual or severe headaches <input type="checkbox"/> Numbness and tingling
<b>Genitourinary</b> <input type="checkbox"/> Pain with urination <input type="checkbox"/> Flank or back pain <input type="checkbox"/> Unusually frequent or urgent urination <input type="checkbox"/> Difficulty starting urinary stream <input type="checkbox"/> Kidney stones	<b>Respiratory</b> <input type="checkbox"/> Painful breathing <input type="checkbox"/> Unusual shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Previous exposure to tuberculosis (TB)

**PLEASE REVIEW AND INITIAL EVERY SIX (6) MONTHS TO A YEAR.**

DATE REVIEWED	PATIENT INITIALS	DOCTOR INITIALS