MEDICAL HISTORY

YOUR NAME: _____

DATE OF BIRTH: _____ **HEIGHT:** _____**WEIGHT:** _____

THE INFORMATION BELOW WILL HELP TO PROVIDE US WITH AN UNDERSTANDING OF YOUR MEDICAL BACKGROUND. THIS WILL ASSIST US IN YOUR CARE.

FAMILY HISTORY:

	ALIVE	DECEASED	N/A				PLEASE LIST RELATIVE WITH CONDITION
FATHER	❑	❑	❑	DIABETES	YES ❑	NO ❑:	_____
MOTHER	❑	❑	❑	CANCER	YES ❑	NO ❑:	_____
SIBLINGS	❑	❑	❑	HYPERTENSION	YES ❑	NO ❑:	_____
CHILDREN	❑	❑	❑	HEART DISEASE	YES ❑	NO ❑:	_____
				STROKE	YES ❑	NO ❑:	_____
				ARTHRITIS	YES ❑	NO ❑:	_____

SOCIAL HISTORY:

ARE YOU A CURRENT SMOKER? YES ❑ NO ❑ FORMER SMOKER? YES ❑ NO ❑ WHEN DID YOU QUIT?_____

WHAT TIME DO YOU START SMOKING WHEN YOU AWAKE?_____

YEAR STARTED SMOKING _____ HOW MANY PER DAY_____

IF CURRENT SMOKER, ARE YOU INTERESTED IN QUITTING? YES ❑ NO ❑

HAVE YOU HAD A DRINK CONTAINING ALCOHOL IN THE LAST YEAR? YES ❑ NO ❑

HOW OFTEN? ❑ MONTHLY ❑ 2-4 TIMES MONTHLY ❑ 2-3 TIMES WEEKLY ❑ 4 OR MORE TIMES A WEEK

HOW MANY PER DAY: ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7-9 ❑ 10 OR MORE

HOW OFTEN DO YOU HAVE MORE THAN 6 DRINKS ON ONE OCCASION?

❑ NEVER ❑ LESS THAN MONTHLY ❑ WEEKLY ❑ DAILY

HAVE YOU USED DRUGS OTHER THAN WHAT WAS PRESCRIBED WITHIN THE LAST 12 MONTHS? YES ❑ NO ❑

IF YES TYPE? _____ TREATMENT FOR DRUG USE? YES ❑ NO ❑

PLEASE LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS FOR SERIOUS ILLNESS OR INJURIES:

Previous Surgeries	Hospital/Doctor
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Previous Hospitalizations	Hospital/Doctor
1.	
2.	
3.	
4.	
5.	
6.	
7.	

ANY COMPLICATIONS WITH ANESTHESIA? YES ❑ NO ❑ IF YES PLEASE DESCRIBE: _____

_____

ANY COMMUNICABLE DISEASES? YES ❑ NO ❑ IF YES PLEASE DESCRIBE:_____

_____

YOUR NAME_____ DATE OF BIRTH_____

REVIEW OF BODILY SYSTEM: *Please check YES or NO for the following:*

BRIEF DESCRIPTION OF CONDITION , *IF NEEDED*

1. SKIN:
   - Chronic Skin Diseases? YES ❑ NO ❑
2. HEAD AND NECK:
   - Head Injuries? YES ❑ NO ❑
3. RESPIRATORY (Lungs):
   - Asthma YES ❑ NO ❑
   - Chronic Lung Disease / Other YES ❑ NO ❑
   - Shortness of Breath on Exertion? YES ❑ NO ❑
   - Coughing of Blood? YES ❑ NO ❑
   - Exposure to or Have Tuberculosis? YES ❑ NO ❑
4. CARDIOVASCULAR *(Heart and Blood Vessels)*:
   - Mitral Valve Prolapse? YES ❑ NO ❑
   - Heart Murmur? YES ❑ NO ❑
   - Heart Pain (angina pectoris)? YES ❑ NO ❑
   - Heart Attack? YES ❑ NO ❑
   - High Cholesterol? YES ❑ NO ❑
   - High Blood Pressure? YES ❑ NO ❑
   - Frequent Swelling in Legs? YES ❑ NO ❑
   - Blood Clots? YES ❑ NO ❑
   - Phlebitis? YES ❑ NO ❑
   - Bleeding Tendencies? YES ❑ NO ❑
   - Testing Done by a Heart Specialist? YES ❑ NO ❑
5. GASTRO INTESTINAL *(Stomach and Intestines)*:
   - Yellow Jaundice? YES ❑ NO ❑
   - Hepatitis? YES ❑ NO ❑
   - Liver Disease? YES ❑ NO ❑
   - Vomiting Blood? YES ❑ NO ❑
   - Blood in Bowels? YES ❑ NO ❑
   - Unusual Diarrhea? YES ❑ NO ❑
   - Irritable Bowel? YES ❑ NO ❑
   - Hiatal Hernia? YES ❑ NO ❑
   - Acid Reflux? YES ❑ NO ❑
   - History of Ulcers? YES ❑ NO ❑
6. GENITOURINARY *(Urinary Tract)*:
   - Colonoscopy? YES ❑ NO ❑
   - Kidney Disease? YES ❑ NO ❑
   - Urinary Incontinence? YES ❑ NO ❑
   - Urinary Bleeding? YES ❑ NO ❑
   - Pain on Urinating? YES ❑ NO ❑
   - Urinary Frequency? YES ❑ NO ❑
   - For Males: Problems with Prostate? YES ❑ NO ❑

YOUR NAME_____ DATE OF BIRTH_____

REVIEW OF BODILY SYSTEM: *Please check YES or NO for the following:*

BRIEF DESCRIPTION OF CONDITION , *IF NEEDED*

7. NEUROMUSCULAR *(Nervous System)*:

Lupus?	YES ❑	NO ❑
Stroke?	YES ❑	NO ❑
Seizure Disorder?	YES ❑	NO ❑
Migraines?	YES ❑	NO ❑
Multiple Sclerosis?	YES ❑	NO ❑

8. SKELETAL:

Dexascan?	YES ❑	NO ❑
Osteoporosis?	YES ❑	NO ❑
Bone Injury?	YES ❑	NO ❑
Back Injury?	YES ❑	NO ❑
Limitation of Motion:		
Arms?	YES ❑	NO ❑
Legs?	YES ❑	NO ❑
Neck?	YES ❑	NO ❑

9. GLANDULAR

Diabetes?	YES ❑	NO ❑
Hypoglycemia?	YES ❑	NO ❑
Thyroid Disease?	YES ❑	NO ❑

10. IMMUNIZATIONS:

Tetanus? If yes, date done	YES ❑	NO ❑
Influenza? If yes, date done	YES ❑	NO ❑
Pneumonia? If yes, date done	YES ❑	NO ❑
Hepatitis? If yes, date done	YES ❑	NO ❑
Other? If yes, date done	YES ❑	NO ❑
11. Depression?	YES ❑	NO ❑
12. Anxiety?	YES ❑	NO ❑
13. OTHER MEDICAL PROBLEMS?	YES ❑	NO ❑

_____

_____

OSHA (Occupational Safety and Health Administration) and the CDC (Centers for Disease Control) have determined that due to the rise in the incidence of tuberculosis, medical offices are required to ask the following questions to determine the possibility of exposure.

Are you currently experiencing any of the following?

1. Night Sweats?	YES ❑	NO ❑
2. Fever?	YES ❑	NO ❑
3. Two Week Persistant Cough?	YES ❑	NO ❑
4. Bloody Sputum?	YES ❑	NO ❑
5. Unexplained Weight Loss?	YES ❑	NO ❑

I certify that the above information is true to the best of my knowledge _____ Signature _____ Date

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____

YOUR NAME_____ DATE OF BIRTH_____

CURRENT MEDICATIONS / DRUG ALLERGIES

Please list current medication(s) with doses and frequency, including aspirin, over the counter medications, diet or herbal supplements and vitamins : ❑ CHECK HERE IF NONE

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Name: _____ Dose: _____ Frequency:_____

Drug allergies? YES ❑ NO ❑ (list) _____
_____

Do you have any sensitivities or allergies to metal or jewelry? YES ❑ NO ❑ (list) _____
_____

Other allergies? YES ❑ NO ❑ (list) _____

Latex allergy? YES ❑ NO ❑

Iodine / Shellfish allergy? YES ❑ NO ❑

Signature_X_____Date_____

Updated: _____Updated: _____Updated: _____

Updated: _____Updated: _____Updated: _____

Updated: _____Updated: _____Updated: _____

Updated: _____Updated: _____Updated: _____

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