

MEDICAL HISTORY

Name _____ Today's Date _____

Age _____ Referred by _____

Previous surgeries (with dates) _____

Other hospitalizations _____

Your medications (including aspirin) _____

Allergies to medications (What is the reaction?) _____

Does anyone in your family have (circle): cancer heart disease diabetes High blood pressure

Any other medical condition? _____

Do you drink alcohol? If so, how much? _____

Do you smoke? If so, how much? _____

Local medical doctor _____

Have you ever had (circle):

- | | | | | | |
|----------------|--------------|-------------------|------------------|--------------------|---------------------|
| Heart problems | angina | valve disease | rheumatic fever | heart attack | high blood pressure |
| Lung problems | asthma | emphysema | bronchitis | collapsed lung | chronic cough |
| Blood problems | anemia | bleeding tendency | transfusion | easy bruisability | |
| Endocrine | diabetes | thyroid disease | | | |
| Other | head injury | seizures | liver trouble | hepatitis | ulcer |
| Eyes | constipation | arthritis | tuberculosis | difficulty hearing | kidney problems |
| | glasses | contact lenses | cataract surgery | | |

Any other medical condition not listed _____

WOMEN: pregnant tubal ligation post menopausal use oral contraceptives

Number of children and ages _____

Height _____ Weight _____

For office use: VS _____ BP _____ P _____ R _____ T _____

Chief complaint _____