MEDICAL HISTORY

Name: ________________________________SS#: ______________________Date: _________
Street Address____
City_______________________State___________Zip__________________________________
Birthday: _____________________Age________Sex________Height________Weight______
Cell phone _________________________Home phone________________________________

Email:____

May we send you email including news and specials about the practice? Yes No

Family Doctor: _________________________Location_________________________________

Employer: _____________________________Employer phone: ___________________________
Occupation:____
Employer address: ____

How were you referred to our office?

What is reason for your visit today? (Your concerns are very important to us. Please describe any concerns you would like the doctor or staff to discuss with you today)

Have you consulted with any other physician about this? If yes, whom?

List all **Medications** you currently take including **Herbal Supplements**/vitamins?

List any **Allergies** you have:

List past & current **Medical Problems**:

Describe all prior **Hospitalizations** & dates:

Past Surgical History

List any **Surgeries** you have had & dates:

Social History

Do you smoke? Yes No — If yes, how many cigarettes/day?__________
Did you smoke in the past? Yes No — If yes, how many for how long?___________
Do you drink alcohol? Yes No — If yes, how many drinks per week? ________

Do you take drugs not prescribed by a doctor? Yes No

Past/Current Medical History (check all that applies and describe above)

__ Anxiety __ Embolism __ HIV/AIDS __ Endocrine Disorder
__ Arthritis __ Emphysema __ Hypertension __ Psychiatric
__ Asthma __ Eye Problem __ Insulin Use __ Breast Problem
__ Bleeding Problem __ Drug Dependance __ Keloids __ Intestinal Problem
__ Bladder Problem __ Epilepsy __ Kidney Problem __ Muscle Disorder
__ Blood Clots __ Glaucoma __ Liver Problem __ Bone Disorder
__ Bruise Easily __ Insulin Use __ Lung Problem __ Urinary Problem
__ Cancer __ Infectious Dz __ Mood Disorder __ Cardiac Problem
__ Cirrhosis __ Heart Attack (MI) __ Neurological Disorder
__ COPD __ Heart Problem __ Seizure __Vascular Problem
__ Diabetes __ Hepatitis __ Skin Disorder __ Fractures
__ Depression __ Hernia __ Stroke __ Mouth Problem
__ Ear Problem __ High Blood Pressure __ Thyroid Problem __ Prostate Problem
__ Other: ____

Do you **scar** easily, or are you prone to hypertrophic or keloid scarring? Yes No

Are you up to date on your immunizations? Yes No

If you were injured, did it occur at work?

Family History

Is there **any** history of medical problems in your family? (For women, please include any history of breast cancer or disease)

Review of Systems

Check any of the following that you have had **recently**:

__ fever __ night sweats __coughing __ chills __weakness
__ eye pain __ vision changes __ ear pain __feeling tired __nose bleeds
__ sore throat __ excessive thirst __ weight loss (unintentional) ?lbs:_________
__ redness __ pain __swelling __ wound drainage __ bleeding __ itching
__ change in skin color __ dark or bleeding skin lesions

Females: (if applicable)
Are you pregnant or possibly pregnant? Yes No
# of pregnancies_____ # of children_____
Do you have any history of breast disease or breast cancer? Yes No
Do you have any acute or chronic Breast Pain, Lumps, Discharge? Yes No
What was the date and findings of your last mammogram?

Have you had **Radiation Therapy** and/or **Chemo Therapy** in the past? (please describe) Yes No

Past Anesthesia History

Have you had **Anesthesia** in the past? Yes No What type of anesthesia? Local General
Describe any problems?