



MEDICAL HISTORY FORM

Date: _____

Patient Name: _____
(First) (Middle) (Last)

Street Address: _____
(Mailing Address)

(City) (State) (Zip)

SEX _____
(M or F)

Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Instructions

Please fill in entire circle as accurately and completely as possible with a dark pen. Example : ● Correct - ○ please do not use a × or ✓ in the ○

Please answer every question with an answer

This information is for your current medical status

Social History

Alcohol: O Yes O No

Smoking: O Yes O No

Sexually active: O Yes O No

Recreational drug use: O Yes O No

Exercise: Yes No

Caffeine: Yes No

Family History

Mother Cancer High BP Heart Disease
 Strokes Mental Disease

Mother Alcohol or Drug Addiction Glaucoma
 Bleeding Disease Other (Diabetes)

Siblings Cancer High BP Heart Disease
 Strokes Mental Disease

Siblings Alcohol or Drug Addiction Glaucoma
 Bleeding Disease Other (Diabetes)

Children Cancer High BP Heart Disease
 Strokes Mental Disease

Children Alcohol or Drug Addiction Glaucoma
 Bleeding Disease Other (Diabetes)

Father Cancer High BP Heart Disease
 Strokes Mental Disease

Father Alcohol or Drug Addiction Glaucoma
 Bleeding Disease Other (Diabetes)

CONSTITUTIONAL

weight gain	<input type="radio"/>	Yes	<input type="radio"/>	No
loss of appetite	<input type="radio"/>	Yes	<input type="radio"/>	No
fever	<input type="radio"/>	Yes	<input type="radio"/>	No
weakness	<input type="radio"/>	Yes	<input type="radio"/>	No
breast feeding	<input type="radio"/>	Yes	<input type="radio"/>	No
weight loss	<input type="radio"/>	Yes	<input type="radio"/>	No
fatigue	<input type="radio"/>	Yes	<input type="radio"/>	No
appetite reduced	<input type="radio"/>	Yes	<input type="radio"/>	No

HEENT (ENT)

cold	<input type="radio"/>	Yes	<input type="radio"/>	No
cough	<input type="radio"/>	Yes	<input type="radio"/>	No
epistaxis(nose bleed)	<input type="radio"/>	Yes	<input type="radio"/>	No
hearing loss	<input type="radio"/>	Yes	<input type="radio"/>	No
change in voice	<input type="radio"/>	Yes	<input type="radio"/>	No
sore throat	<input type="radio"/>	Yes	<input type="radio"/>	No
ringing in ears	<input type="radio"/>	Yes	<input type="radio"/>	No
sinus pain	<input type="radio"/>	Yes	<input type="radio"/>	No
ear fullness	<input type="radio"/>	Yes	<input type="radio"/>	No
itchy eyes	<input type="radio"/>	Yes	<input type="radio"/>	No
runny nose	<input type="radio"/>	Yes	<input type="radio"/>	No
scratchy throat	<input type="radio"/>	Yes	<input type="radio"/>	No
sinus congestion	<input type="radio"/>	Yes	<input type="radio"/>	No

RESPIRATORY

shortness of breath	<input type="radio"/>	Yes	<input type="radio"/>	No
chest pain	<input type="radio"/>	Yes	<input type="radio"/>	No
chest congestion	<input type="radio"/>	Yes	<input type="radio"/>	No
cough	<input type="radio"/>	Yes	<input type="radio"/>	No

CARDIOLOGY

dizziness	<input type="radio"/>	Yes	<input type="radio"/>	No
chest pain	<input type="radio"/>	Yes	<input type="radio"/>	No
palpitations	<input type="radio"/>	Yes	<input type="radio"/>	No
leg edema	<input type="radio"/>	Yes	<input type="radio"/>	No
shortness of breath	<input type="radio"/>	Yes	<input type="radio"/>	No
varicose veins	<input type="radio"/>	Yes	<input type="radio"/>	No

GASTROENTEROLOGY

blood in stool	<input type="radio"/>	Yes	<input type="radio"/>	No
diarrhea	<input type="radio"/>	Yes	<input type="radio"/>	No
vomiting	<input type="radio"/>	Yes	<input type="radio"/>	No
constipation	<input type="radio"/>	Yes	<input type="radio"/>	No
nausea	<input type="radio"/>	Yes	<input type="radio"/>	No
trouble swallowing	<input type="radio"/>	Yes	<input type="radio"/>	No
abdominal pain	<input type="radio"/>	Yes	<input type="radio"/>	No
heartburn	<input type="radio"/>	Yes	<input type="radio"/>	No
hemorrhoids	<input type="radio"/>	Yes	<input type="radio"/>	No

FEMALE REPRODUCTIVE

hot flashes	<input type="radio"/>	Yes	<input type="radio"/>	No
abnormal vaginal discharge	<input type="radio"/>	Yes	<input type="radio"/>	No
heavy periods	<input type="radio"/>	Yes	<input type="radio"/>	No
painful intercourse	<input type="radio"/>	Yes	<input type="radio"/>	No
sexually active	<input type="radio"/>	Yes	<input type="radio"/>	No
painful periods	<input type="radio"/>	Yes	<input type="radio"/>	No
infertility	<input type="radio"/>	Yes	<input type="radio"/>	No
frequent yeast infections	<input type="radio"/>	Yes	<input type="radio"/>	No
pelvic pain	<input type="radio"/>	Yes	<input type="radio"/>	No
breast pain	<input type="radio"/>	Yes	<input type="radio"/>	No
nipple discharge	<input type="radio"/>	Yes	<input type="radio"/>	No
birth control	<input type="radio"/>	Yes	<input type="radio"/>	No
menopause	<input type="radio"/>	Yes	<input type="radio"/>	No

MALE REPRODUCTIVE

difficulty with erection	<input type="radio"/>	Yes	<input type="radio"/>	No
diminished sexual drive	<input type="radio"/>	Yes	<input type="radio"/>	No
penile discharge	<input type="radio"/>	Yes	<input type="radio"/>	No
contraception	<input type="radio"/>	Yes	<input type="radio"/>	No

MUSCULOSKELETAL

joint stiffness	<input type="radio"/>	Yes	<input type="radio"/>	No
leg cramps	<input type="radio"/>	Yes	<input type="radio"/>	No

joint pain	<input type="radio"/>	Yes	<input type="radio"/>	No
joint swelling	<input type="radio"/>	Yes	<input type="radio"/>	No
sciatica	<input type="radio"/>	Yes	<input type="radio"/>	No
osteoporosis treatment	<input type="radio"/>	Yes	<input type="radio"/>	No
fracture	<input type="radio"/>	Yes	<input type="radio"/>	No
carpal tunnel	<input type="radio"/>	Yes	<input type="radio"/>	No

HEMATOLOGY/LYMPH

swollen glands	<input type="radio"/>	Yes	<input type="radio"/>	No
fatigue	<input type="radio"/>	Yes	<input type="radio"/>	No
loss of appetite	<input type="radio"/>	Yes	<input type="radio"/>	No
varicose veins	<input type="radio"/>	Yes	<input type="radio"/>	No
easy bruising	<input type="radio"/>	Yes	<input type="radio"/>	No

DERMATOLOGY

rash	<input type="radio"/>	Yes	<input type="radio"/>	No
mole	<input type="radio"/>	Yes	<input type="radio"/>	No
lumps	<input type="radio"/>	Yes	<input type="radio"/>	No
dry or sensitive skin	<input type="radio"/>	Yes	<input type="radio"/>	No
hives	<input type="radio"/>	Yes	<input type="radio"/>	No
acne	<input type="radio"/>	Yes	<input type="radio"/>	No
skin cancer	<input type="radio"/>	Yes	<input type="radio"/>	No

NEUROLOGY

headache	<input type="radio"/>	Yes	<input type="radio"/>	No
tingling numbness	<input type="radio"/>	Yes	<input type="radio"/>	No
seizures	<input type="radio"/>	Yes	<input type="radio"/>	No
insomnia	<input type="radio"/>	Yes	<input type="radio"/>	No
memory loss	<input type="radio"/>	Yes	<input type="radio"/>	No
dizziness	<input type="radio"/>	Yes	<input type="radio"/>	No
gait abnormality	<input type="radio"/>	Yes	<input type="radio"/>	No

PSYCHOLOGY

depression	<input type="radio"/>	Yes	<input type="radio"/>	No
high stress level	<input type="radio"/>	Yes	<input type="radio"/>	No
sleep disturbances	<input type="radio"/>	Yes	<input type="radio"/>	No
suicidal ideation	<input type="radio"/>	Yes	<input type="radio"/>	No
eating disorder	<input type="radio"/>	Yes	<input type="radio"/>	No
mental or physical abuse	<input type="radio"/>	Yes	<input type="radio"/>	No
anxiety	<input type="radio"/>	Yes	<input type="radio"/>	No

OPHTHALMOLOGY

diminished vision	<input type="radio"/>	Yes	<input type="radio"/>	No
eye irritation	<input type="radio"/>	Yes	<input type="radio"/>	No
drainage from eyes	<input type="radio"/>	Yes	<input type="radio"/>	No
blurring of vision	<input type="radio"/>	Yes	<input type="radio"/>	No

seasonal eye symptoms	<input type="radio"/>	Yes	<input type="radio"/>	No
loss of vision	<input type="radio"/>	Yes	<input type="radio"/>	No

UROLOGY

difficulty urinating	<input type="radio"/>	Yes	<input type="radio"/>	No
blood in urine	<input type="radio"/>	Yes	<input type="radio"/>	No
frequent urination	<input type="radio"/>	Yes	<input type="radio"/>	No
urinary incontinence(leakage)	<input type="radio"/>	Yes	<input type="radio"/>	No
recurrent UTI	<input type="radio"/>	Yes	<input type="radio"/>	No
nighttime urination	<input type="radio"/>	Yes	<input type="radio"/>	No
impotence	<input type="radio"/>	Yes	<input type="radio"/>	No

ENDOCRINOLOGY

fatigue	<input type="radio"/>	Yes	<input type="radio"/>	No
thirst	<input type="radio"/>	Yes	<input type="radio"/>	No
excessive urination	<input type="radio"/>	Yes	<input type="radio"/>	No
weight loss	<input type="radio"/>	Yes	<input type="radio"/>	No
sleep disturbance	<input type="radio"/>	Yes	<input type="radio"/>	No
cold intolerance	<input type="radio"/>	Yes	<input type="radio"/>	No
heat intolerance	<input type="radio"/>	Yes	<input type="radio"/>	No
diabetes	<input type="radio"/>	Yes	<input type="radio"/>	No

Allergies to any Medications, X-Ray Dyes, or other Substances

(yes)

(no)

If yes, please list names of medicines and type of reactions)

Current Medications

(Please list any and all medications to include prescription and over the counter, vitamins and herbs, etc.)

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

