

# MEDICAL HISTORY

Name:  
Today's Date:  
Date of Birth:



Drug Allergies		Medications	

Medical History			
<input type="checkbox"/> Abdominal Pain – Chronic	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Allergies/Hayfever	<input type="checkbox"/> Gout	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Measles <input type="checkbox"/> Rubella
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Ankles – Swollen	<input type="checkbox"/> Headaches – Frequent	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Appetite – Loss of	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sexual/Menstrual Dysfunction	<input type="checkbox"/> Herpes
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Other:
<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Hernia	<input type="checkbox"/> Stools – Bloody or Tarry	<b>FEMALES – Please Complete</b>
<input type="checkbox"/> Back Pain – Recurrent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bone Fracture/Joint Injury	<input type="checkbox"/> Indigestion or Heartburn	<input type="checkbox"/> Swallowing Difficulty	Planning Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bowel Habits – Change in	<input type="checkbox"/> Infections – Frequent	<input type="checkbox"/> Tetanus	Menstrual Flow:
<input type="checkbox"/> Bronchitis/Chronic Cough	<input type="checkbox"/> Jaundice/Hepatitis	<input type="checkbox"/> Throat – Sore – Frequent	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain / Cramps
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Thyroid Disease	Days of flow      Length of Cycle
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Tremor / Hands Shaking	Date – 1 <sup>st</sup> day of last period:
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Leg Pain - Walking	<input type="checkbox"/> Ulcers - Peptic	<input type="checkbox"/> Pain/Bleeding during or after sex.
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Urethral Discharge	Number of:
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Urination- <input type="checkbox"/> Overnight>Than Twice	Pregnancies      Abortions
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Moodiness - Excessive	<input type="checkbox"/> Decrease in Force/Flow	Miscarriages      Live Births
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control	Birth Control Method
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Nausea/Vomiting – Persistent	<input type="checkbox"/> Urine – Blood in	B.C. Pill (Name):
<input type="checkbox"/> Ear Infections – Frequent	<input type="checkbox"/> Nervousness <input type="checkbox"/> Depression	<input type="checkbox"/> Varicose Veins/Phlebitis	<input type="checkbox"/> Flushing/Menopause
<input type="checkbox"/> Ear – Ringing In	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Venereal Disease	Date of Last PAP Test
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Numbness/Tingling Sensations	<input type="checkbox"/> Vision - Failing	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> Fatigue - Chronic	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Weight Loss	Date of Last Mammogram
<input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet	<input type="checkbox"/> Phobias		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Family History													
	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:						
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:						

Habits			
<input type="checkbox"/> Alcohol: Type	<input type="checkbox"/> Diet: Salt Intake	<input type="checkbox"/> Sleep: Difficulty Falling Asleep	<input type="checkbox"/> Smoke: Packs Daily
Amount	Fat Intake	Continuity Disturbances	How long?
<input type="checkbox"/> Coffee: Cups Daily	Other	Early Morning Awakening	Interested in stopping?
Other Caffeine	<input type="checkbox"/> Exercise Routine:	Daytime Drowsiness	
		Other:	

Comments: