

Patient Medical History

Patient Name: _____

Date: _____

<p>HEAD/EARS/EYES <input type="checkbox"/> NORMAL <input type="checkbox"/> Cataracts <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Loss / Aids <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Other: _____</p> <p>NOSE/THROAT/MOUTH <input type="checkbox"/> NORMAL <input type="checkbox"/> Allergies <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other: _____</p> <p>SKIN <input type="checkbox"/> NORMAL <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Other: _____</p> <p>CARDIOVASCULAR <input type="checkbox"/> NORMAL <input type="checkbox"/> Arrythmia <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Attack <input type="checkbox"/> Hypertension <input type="checkbox"/> Murmur <input type="checkbox"/> Angina <input type="checkbox"/> Angioplasty <input type="checkbox"/> Valve disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Other: _____</p> <p>IMMUNE SYSTEM <input type="checkbox"/> NORMAL <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Human Immunodeficiency Virus (HIV) <input type="checkbox"/> Other: _____</p> <p>CANCER <input type="checkbox"/> If so, where? _____ How Long? _____</p>	<p>GASTROINTESTINAL <input type="checkbox"/> NORMAL <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Ulcers <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Reflux <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Vomiting <input type="checkbox"/> Crohns Disease <input type="checkbox"/> Hepatitis <u> </u>A, <u> </u>B, <u> </u>C <input type="checkbox"/> Other: _____</p> <p>KIDNEYS or URINARY <input type="checkbox"/> NORMAL <input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Renal failure <input type="checkbox"/> Other: _____</p> <p>MUSCULOSKELETAL <input type="checkbox"/> NORMAL <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lupus <input type="checkbox"/> Gout <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other: _____</p> <p>NEUROLOGICAL <input type="checkbox"/> NORMAL <input type="checkbox"/> Depression <input type="checkbox"/> Polio <input type="checkbox"/> Parkinson <input type="checkbox"/> Epilepsy <input type="checkbox"/> Alzheimers <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Sclerosis <input type="checkbox"/> Brain Surgery <input type="checkbox"/> Paralysis <input type="checkbox"/> Other: _____</p>	<p>HEMATOLOGIC/LYMPHATIC <input type="checkbox"/> NORMAL <input type="checkbox"/> Polycythemia <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Anemia <input type="checkbox"/> Aplastic Anemia <input type="checkbox"/> Thalassemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Low Platelets <input type="checkbox"/> Other: _____</p> <p>VASCULAR <input type="checkbox"/> NORMAL <input type="checkbox"/> Phlebitis <input type="checkbox"/> Raynauds <input type="checkbox"/> DVT <input type="checkbox"/> Claudication <input type="checkbox"/> Hemophilia <input type="checkbox"/> Other: _____</p> <p>ENDOCRINE <input type="checkbox"/> NORMAL <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Diabetes Type: <u> </u> <input type="checkbox"/> Other: _____</p> <p>RESPIRATORY <input type="checkbox"/> NORMAL <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Chest Pain <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Other: _____</p> <p>SURGERIES (PREVIOUS): Orthopaedic: _____ OB/GYN: _____ Cosmetic: _____ Other: _____</p>
---	---	--

FAMILY & SOCIAL HISTORY

List any known Drug Allergies: _____

Do you currently take any Medications? If so, please list them by name, strength, times per day, and prescribing physician: _____

Are you pregnant? _____

Do you have any significant health problems? If so, please list them: _____

Family History:

Mother	Age: _____	Medical Problems: _____
Father	Age: _____	Medical Problems: _____
Siblings	Age: _____	Medical Problems: _____
	Age: _____	Medical Problems: _____

Social History:

Do you use any tobacco products? Yes _____ No _____ If so, which ones? _____

Have you ever used tobacco products? Yes _____ No _____ If so, how long? _____

When did you stop? _____

Do you drink alcoholic beverages? YES _____ NO _____ IF so, how much and how often? _____

Do you now or have you ever used addictive drugs? Yes _____ No _____ If so, what kind and when? _____