

MEDICAL HISTORY FORM

PAST MEDICAL HISTORY:

Have you or has any family member, ever had the any of following? Check if Yes - leave blank if No

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Goiter | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bad Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Disease |

Other significant illness, please list: _____

CURRENT MEDICATIONS:

MEDICATIONS	DOSE/HOW OFTEN	PRESCRIBING MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICINE ALLERGIES/INTOLERANCES:

MEDICATION	SYMPTOMS
_____	_____
_____	_____
_____	_____
_____	_____

GENERAL HEALTH:	NERVOUS SYSTEM:	THROAT:
<input type="checkbox"/> Recent weight gain/loss	<input type="checkbox"/> Headaches	<input type="checkbox"/> Frequent Sore Throats
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Weakness	<input type="checkbox"/> Muscle Spasm	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Fever	<input type="checkbox"/> Loss of consciousness	
<input type="checkbox"/> Fainting	<input type="checkbox"/> Sensitivity of pain in hands or feet	

HEART AND LUNGS:	MUSCLE/JOINTS/BONE:
<input type="checkbox"/> Pain in chest	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Sudden changes in heartbeat	<input type="checkbox"/> Muscle Tender
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Joint Stiffness
<input type="checkbox"/> Difficulty in breathing at night	_____ Lasting how long? _____
<input type="checkbox"/> Swollen legs or feet	

STOMACH AND INTESTINES:

- _____ Nausea
- _____ Vomiting of blood or coffee ground material
- _____ Stomach pain relieved by food or milk
- _____ Yellow jaundice
- _____ Increasing constipation
- _____ Persistent diarrhea
- _____ Blood in stools
- _____ Black stools
- _____ Heartburn

BLOOD:

- _____ Anemia
- _____ Easy Bruising
- _____ Redness
- _____ Rash
- _____ Hives
- _____ Tightness
- _____ Nodules/lumps
- _____ Hair Loss
- _____ Color change of hands or feet when cold

Please describe any conditions you think we should know about: _____

PREVIOUS OPERATIONS:

TYPE OF SURGERY	YEAR	SURGEON
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any previous fractures? _____ Describe: _____

Any other serious injuries? _____ Describe: _____

PERSONAL HABITS:

Do you drink coffee? _____ Number of cups per day _____

Do you smoke? _____ Number of cigarettes per day _____

Has anyone told you to cut down on drinking? _____

Do you use drugs for reasons that are not medical? _____