MEDICAL HISTORY

All information will be held in strict confidence.

Patient's Name _____ Birthdate _____

Primary Care Physician _____ City _____ Physician's Phone (_____) _____

List the **MEDICAL SPECIALISTS** you have seen

Physician's Name	Specialty	Physician's Name	Specialty

DESCRIBE YOUR OVERALL HEALTH: ☐ Outstanding (better than most people my age) ☐ Good (I don't know of any medical problem)
☐ Fair (I have some health problems but they're under control) ☐ Guarded (I have some current health problems) ☐ Poor (I have some major health problems)

WHEN WAS THE LAST TIME YOU SAW YOUR PHYSICIAN? _____(year) What was the purpose? _____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS? ☐ No ☐ Yes, describe _____

HABITS

Cigarettes ☐ Never smoked ☐ Smoked but quit. When? _____ ☐ Currently smoking. Amount? _____ Start date _____
☐ Cigars or ☐ Pipe: ☐ Never smoked ☐ Smoked but quit. When? _____ ☐ Currently smoking. Amount? _____ Start date _____
Smokeless tobacco: ☐ Never smoked ☐ Used, but quit. When? _____ ☐ Currently using. Amount? _____ Start date _____
Have you tried to quit? ☐N/A ☐ No ☐ Yes How many times? _____ What technique did you use? ☐ Abstain ☐ Nicotine patches ☐ Nicotine gum ☐ Hypnosis

Alcohol Consumption: ☐ Total abstinence ☐ Other, describe frequency & amount _____

Do you use any recreational drugs? ☐ No ☐ Yes

WOMEN

Are you pregnant? ☐ No ☐ Yes, estimated due date _____ Are you nursing? ☐ No ☐ Yes
Are you taking oral contraceptives? ☐ No ☐ Yes Are you undergoing hormone replacement therapy? ☐ No ☐ Yes
Are you under treatment for osteoporosis and taking a class of medications call BISPHOSPHONATES? ☐ No ☐ Yes, which one _____
(Some [BUT NOT ALL] *common names include Actonel®, Boniva®, Fosamax®, Fosamax Plus D®, Skelid® & Didronel®)*

ALLERGIES: Are you allergic to any of the following? ☐ Check here, if no known allergies

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other antibiotics ☐ Codeine ☐ Local anesthetic ☐ Aspirin ☐ NSAIDs like Motrin® ☐ Metals ☐ Other _____
Name the specific medication and describe your reaction:

Do you have or have you had any of the following?

HEART/VASCULAR
- ☐ ☐ Heart attack (MI)
- ☐ ☐ Congenital heart defect
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Irregular heartbeat (missed beats)
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Angina / Chest pains
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Artificial heart valve(s)
- ☐ ☐ Pacemaker
- ☐ ☐ By-pass surgery
- ☐ ☐ Stent placement
- ☐ ☐ Congestive heart failure
- ☐ ☐ Swelling of ankles
- ☐ ☐ Shortness of breath
- ☐ ☐ Other heart disease

BLOOD
- ☐ ☐ Anemia
- ☐ ☐ Sickle cell disease
- ☐ ☐ Hemophilia
- ☐ ☐ Bruise very easily
- ☐ ☐ Prolonged bleeding
- ☐ ☐ HIV / AIDS

RESPIRATORY
- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Persistent cough
- ☐ ☐ Coughing up blood/sputum
- ☐ ☐ Difficulty breathing while lying down
- ☐ ☐ Winded going up 1 flight of stairs
- ☐ ☐ Lung cancer
- ☐ ☐ Other lung disease

BONE
- ☐ ☐ Arthritis / Rheumatism
- ☐ ☐ Osteoporosis
- ☐ ☐ Gout
- ☐ ☐ Artificial joints or limbs

URINARY
- ☐ ☐ Kidney disease
- ☐ ☐ Renal dialysis
- ☐ ☐ Very frequent urination
- ☐ ☐ Burning on urination
- ☐ ☐ Blood or discharge in urine
- ☐ ☐ Venereal disease
- ☐ ☐ Genital herpes

NERVOUS SYSTEM
- ☐ ☐ Stroke (CVA) or TIA
- ☐ ☐ Severe headaches / Migraines
- ☐ ☐ Fainting or dizzy spells
- ☐ ☐ Convulsions or epilepsy
- ☐ ☐ Numbness or tingling

ENDOCRINE
- ☐ ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ ☐ Excessive thirst
- ☐ ☐ Thyroid disease
- ☐ ☐ Hypoglycemia

MENTAL HEALTH
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Panic attacks
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Bipolar (manic – depressive)
- ☐ ☐ Addiction disorders _____
- ☐ ☐ Other _____

HEAD/NECK/EYES
- ☐ ☐ Glaucoma
- ☐ ☐ Macular Degeneration
- ☐ ☐ Loss of hearing
- ☐ ☐ Tonsillitis
- ☐ ☐ Sinus problems

DIGESTIVE SYSTEM
- ☐ ☐ Hepatitis, Type ____
- ☐ ☐ Gastric reflux
- ☐ ☐ Ulcers
- ☐ ☐ Frequent diarrhea
- ☐ ☐ Crohn's dis. or colitis

CANCER
- ☐ ☐ Tumor _____
- ☐ ☐ Radiation treatment
- ☐ ☐ Chemotherapy
- ☐ ☐ Organ removal

☐ ☐ **ORGAN TRANSPLANT**

TO THE BEST OF MY KNOWLEDGE, ALL THE ABOVE INFORMATION IS CORRECT.

Signed _____ Date _____

DOCTOR'S NOTES

21 X 13

Patient's Name _____

List any surgeries or major health events	
Year	Event

Medications INCLUDING over-the-counter medications and herbal supplements		
Name of medicine	Dosage	Purpose: Why are you taking it?

MEDICAL HISTORY UPDATES

1 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

2 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

3 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

4 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

5 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

6 ____/____/____ (Month / Day / Year) ____/____ BP: ☐ R arm ☐ L arm

☐ Y ☐ N Change in health? _____
☐ Y ☐ N Under MD's care? ☐ Y ☐ N Rx change?
☐ Y ☐ N New allergies? Tobacco? ☐ N/A ☐ Same ☐ Started ☐ Quit ____
☐ Y ☐ N Pregnant? EDD _____ ☐ Y ☐ N Nursing?

Antibiotic prophy? ☐ N/A ☐ Taken as directed _____

I ATTEST THAT I HAVE REVIEWED MY MEDICAL HISTORY & IT IS ACCURATE, AS AMENDED. _____

Reviewed by

21 X 13