MEDICAL HISTORY

Name:_____ Age:_____ DOB:_____ Height: _____ Weight:_____ Date:_____

Reason for visit: _____ Referring Physician(s):_____

Allergies:_____
(Medications, Iodine, IV dye/contrast, Latex, Adhesive, etc.)

Medication & Dosage:
(Include Aspirin, Supplements, Diet & Birth control pills)

Medication	Dosage/day	Medication	Dosage/day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pre-Operative Antibiotics required? Yes ☐ No ☐

(Typically pre-operative antibiotics are required if your doctor has told you. Due to: Cardiac murmur, Mitral valve prolapse, Artificial joints, or when you go to the dentist to get your teeth cleaned you have to receive antibiotics first)

History of **MRSA** infection? Yes ☐ No ☐

History of Hepatitis? Yes ☐ No ☐

Do you experience the following symptoms?

General:
☐ Weight Change
☐ Fatigue
☐ Night Sweats/ Fevers
☐ Heat/ Cold Intolerance

Chest:
☐ Coughing (Phlegm/ Blood)
☐ Wheezing/ Shortness of breath
☐ Chest Pain/ Pressure
☐ Irregular Heart Beat/ Palpitations

Urinary:
☐ Voiding Small/ Large amounts
☐ Decreased force of stream
☐ Pain/ burning frequency
☐ Blood in urine
☐ Incontinence

Eyes/ Nose/ Mouth:
☐ Vision Changes
☐ Nose Bleeds
☐ Sinus Problems
☐ Sores/ Blisters
☐ Sore Throat
☐ Hoarseness
☐ Pain/ Difficulty Swallowing

Skin:
☐ Moles/ Sunspots/ Bruises
☐ Changes in Hair/ Nails

Nervous System:
☐ Headaches
☐ Anxiety/ Depression
☐ Insomnia/ Excessive snoring
☐ Dizziness/ Fainting
☐ Seizures

TURN OVER →

Abdomen:
☐ Appetite loss
☐ Pain/ Cramping
☐ Bloating/ Belching/ Gas
☐ Heartburn
☐ Nausea/ Vomiting
☐ Diarrhea/ Constipation
☐ Bloody Stools
☐ Change in Stools

Breast:
☐ Lump/ Pain
☐ Nipple Discharge
☐ Skin Changes
☐ Swollen Lymph nodes

Arms & Legs:
☐ Muscle cramps/ Weakness
☐ Pain/ Swelling/ Numbness
☐ Blue fingers/ Toes
☐ Yellow/ Jaundice Skin

MEDICAL HISTORY

Y= You F= Family (Mother, Father, Sibling)

Cancer:

☐ Y Type:_____

☐ F Type:_____

Heart Murmur	☐ Y	☐ F
Mitral Valve Prolapse	☐ Y	☐ F
Stroke	☐ Y	☐ F
High Blood Pressure	☐ Y	☐ F
Congestive Heart Failure	☐ Y	☐ F
Atrial Fibrillation	☐ Y	☐ F
Heart Attack	☐ Y	☐ F
Rheumatic Fever	☐ Y	☐ F
Sleep Apnea: Use C-pap? _____	☐ Y	☐ F
Asthma	☐ Y	☐ F
COPD (Emphysema)	☐ Y	☐ F
Pneumonia	☐ Y	☐ F
Anemia: Current or History? _____	☐ Y	☐ F
Hemophelia	☐ Y	☐ F
Blood Clots: DVT or PE? _____	☐ Y	☐ F
Gallbladder problems	☐ Y	☐ F
Diabetes: IDDM or NIDDM? _____	☐ Y	☐ F
Hypoglycemia	☐ Y	☐ F
Kidney problems: Type? _____	☐ Y	☐ F
Spleen problems	☐ Y	☐ F
Thyroid problems: Hyper or Hypo? ___	☐ Y	☐ F
Hernia: Type? _____	☐ Y	☐ F
Appendicitis	☐ Y	☐ F
Diverticulosis	☐ Y	☐ F
Colonic Polyps: Family Member _____	☐ Y	☐ F
Crohn's Disease: Family Member _____	☐ Y	☐ F
Ulcerative Colitis: Family Member _____	☐ Y	☐ F
Irritable Bowel Syndrome	☐ Y	☐ F
Hemorrhoids	☐ Y	☐ F
Prostate Disease	☐ Y	☐ F
Acid Reflux	☐ Y	☐ F
Stomach Ulcers	☐ Y	☐ F
Uterus problems	☐ Y	☐ F
Ovarian problems	☐ Y	☐ F
Sexually Transmitted Diseases	☐ Y	☐ F
Arthritis	☐ Y	☐ F
Fibromyalgia	☐ Y	☐ F
Neurologic problems	☐ Y	☐ F
Psychiatric problems	☐ Y	☐ F
Other:_____	☐ Y	☐ F

SURGICAL HISTORY

☐ Brain: Type? _____	☐ Defibrillator	☐ Tubal Ligation	☐ Vasectomy
☐ Cataracts	☐ Appendix	☐ Prostate	☐ Varicose Veins
☐ Sinus	☐ Kidney	☐ Spleen	☐ Hysterectomy
☐ Tonsils	☐ Small Bowel	☐ Colon Resection	☐ Back Surgery
☐ Thyroid: Type?_____	☐ Hemorrhoidectomy	☐ Anal Fissure	☐ Ovary removal
☐ Breast: Type? _____	☐ Hernia: Type? _____	☐ Upper Endoscopy (EGD)	☐ Sigmoidoscopy
☐ Heart: Type? _____	☐ Joint Replacement: Hip or Knee?	☐ Gallbladder	☐ Stomach: Type? _____
☐ Arterial Bypass: When? ___	☐ Orthopedic Surgery	☐ Lungs: Type? _____	☐ Colonoscopy: When? _____
☐ Pacemaker	☐ Other:_____		

SOCIAL HISTORY

History of Tobacco use? ☐ Yes ☐ No

Tobacco:_____

(Amount & Frequency)

History of Alcohol abuse? ☐ Yes ☐ No

Alcohol:_____

(Amount & frequency)

Caffeine:_____

(Amount & Frequency)

History of Illegal drugs use? ☐ Yes ☐ No

Drug:_____

(Drug & length of use)

Exercise:_____

(Amount & frequency)

Work: ☐ Employed ☐ Retired

Occupation:_____

Marital Status: ☐ S ☐ M ☐ DP ☐ D ☐ W