

MEDICAL HISTORY

Name _____

Date of Birth _____

Please check the box if you have the problem now or in the past

	Now	Past		Now	Past		Now	Past
General			Urinary			Endocrine		
Weight loss			Frequent urination			Thyroid Problem		
Fever/Chills			Burning			Diabetes		
Fatigue			Blood in urine					
Headaches			Urinary infection			Blood		
			Kidney Stones			Blood clots		
ENT			Incontinence			Bleeding problems		
Hearing loss			Sexual difficulty			Leukemia		
Ringing ears			Male testicle pain			Anemia		
Blurred vision			Female painful menses			Phlebitis		
Earaches			Female vag. discharge			Enlarged spleen		
Nose bleeds						Hepatitis		
Bleeding gums			Musculoskeletal			HIV		
Sore throat			Joint pain			AIDS		
Swollen glands			Stiffness					
			Weakness					
Heart			Back pain					
Heart failure			Cold feet or hands					
Heart Attack			Poor circulation					
Angina								
Leg swelling			Skin/Breast					
Palpitations			Rash/itching					
Rheumatic fever			Change in color					
High Blood Pressure			Varicose veins					
			Breast pain					
Lungs			Breast lump					
Pneumonia			Breast discharge					
Emphysema			Breast cancer					
Bronchitis								
Cancer			Neuro					
Shortness of breath			Dizzy spells					
Spitting blood			Numbness					
Wheezing/Asthma			Seizures					
			Tremors					
Gastrointestinal			Paralysis					
Poor appetite			Head Injury					
Diarrhea								
Constipation			Psychiatric					
Nausea/Vomiting			Memory loss					
Painful bowel move.			Nervousness					
Rectal bleeding			Depression					
Abdominal Pain			Insomnia					
Gall stones								

Please complete the reverse side

Previous Surgeries and Dates:

Social History :

Smoking No Yes How Much _____ How many years _____
Alcohol No Yes How Much _____

Marital Status : S M D W

Family History :

	Age	Medical problems or cause of death
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Current Medications and Doses

Drug Allergies and Reaction
