

PATIENT MEDICAL HISTORY INFORMATION

(CONFIDENTIAL INFORMATION – IMPORTATION FOR OUR FILES AND YOUR HEALTH)

1. State in your words your medical reasons for coming to our office.

2. Please list all medications that you use. _____

3. Please list all operations that you have had and the year performed. _____

4. Do you smoke? _____ Packs per day _____

5. Please list any allergies to medications _____

6. Please indicate which of your relative have had any of the following diseases:

Cancer _____ Diabetes _____

Heart Trouble / High Blood Pressure _____

Arthritis _____ Kidney Disease _____

Mental Disease _____ Strokes _____

Gout _____

7. Please indicate “yes” or “no” if you have had significant problems in the below areas:

Recent weight loss: _____

Headaches: _____

Trouble with vision: _____

Trouble with hearing: _____

Allergies / Hayfever: _____

Asthma _____

Thyroid: _____

Diabetes: _____

Skin: _____

Anemia _____

Abnormal Bleeding: _____

Circulation: _____

High Blood Pressure: _____

Chest Pain: _____

Respiratory: _____

TB or Pneumonia _____

Shortness of Breath: _____

Liver Disease _____

Gallbladder Disease: _____

Stomach trouble: _____

Arthritis: _____

Heart: _____

Swelling feet/ankles: _____

8. Have you had any unusual childhood diseases such as polio? _____

9. Do you have any problems taking aspirin? _____

10. FOR WOMEN ONLY: Are you pregnant? _____ If yes, how many months? _____

Patient signature: _____ Date: _____