MEDICAL HISTORY

Date______________________

Name ______________________________ Birthday ____________________ Sex__________ Race __________

HEALTH HISTORY OF THE PATIENT

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
Other Illnesses		

Explain all Yes Answers:

____

____

____

Surgical Procedures (include approx. dates):

____

____

____

____

Current Medications and Dosage:

____

____

____

Allergies to Medicine (None)

____

____

____

FAMILY HISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other Illnesses		

Explain all Yes Answers:

____

____

____

Cause of death of parents, or brothers, or sisters:

____

____

____

SOCIAL HISTORY

Most Recent Occupation ______________________

____

History of Domestic Abuse? ______________________

____

Married ❑ Single ❑ Divorced ❑ Widowed ❑

Number of Children Living ______________________

Number of Pregnancies______________________

Presently Living Alone? Yes ❑ No ❑

Smoke ____________________packs per day

Alcohol: Never ❑ Occasional ❑ Moderate to Heavy ❑

Drug Overuse: ❑ None ❑ Presently ❑ Past Problem ❑

REVIEW OF SYSTEMS

Have you recently had or do you now have

	Yes	No
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills or Fever		
Heart or Chest Pain		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps with Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Frequent Belching		
Frequent Loose Bowel Movements		
Blood in Bowel Movements		
Frequent Constipation		
Hemorrhoids		
Frequent Urination (pass water)		
Burning on Urination		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Get Up Every Night to Urinate		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Hot or Cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		
Women only:		
Irregular Periods		
Vaginal Discharge		
Frequent Spotting		

Date of Last Tetanus ______________________

ADVANCE DIRECTIVE

I do ❑ do not ❑ have an Advance Directive

Type: Living Will ❑ Durable POA ❑

(agent's name) ______________________