

Medical History

Patient Name: _____

Allergies: __adhesive __aspirin __codeine __iodine __latex
__morphine __novocaine __penicillin __sulfa other: _____

Medical Problems (include those being treated and under control)

<input type="checkbox"/> alzheimer's	<input type="checkbox"/> emphysema	<input type="checkbox"/> neuropathy
<input type="checkbox"/> anemia	<input type="checkbox"/> hearing loss	<input type="checkbox"/> prostate cancer
<input type="checkbox"/> angina (chest pain)	<input type="checkbox"/> hypothyroidism	<input type="checkbox"/> paralysis
<input type="checkbox"/> arthritis	<input type="checkbox"/> headaches	<input type="checkbox"/> rash
<input type="checkbox"/> asthma	<input type="checkbox"/> heart attack	<input type="checkbox"/> reflux (gerd)
<input type="checkbox"/> anxiety	<input type="checkbox"/> foot/leg cramps	<input type="checkbox"/> respiratory problems
<input type="checkbox"/> back pain	<input type="checkbox"/> glaucoma	<input type="checkbox"/> ringing in ears
<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> gout	<input type="checkbox"/> seizures/epilepsy
<input type="checkbox"/> congestive heart failure	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> COPD	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> sciatica
<input type="checkbox"/> constipation	<input type="checkbox"/> impaired vision	<input type="checkbox"/> skin cancer
<input type="checkbox"/> diarrhea	<input type="checkbox"/> kidney stones	<input type="checkbox"/> stroke
<input type="checkbox"/> depression	<input type="checkbox"/> leg pain on walking	<input type="checkbox"/> ulcer
<input type="checkbox"/> diabetes	<input type="checkbox"/> lung cancer	<input type="checkbox"/> varicose veins
<input type="checkbox"/> dialysis	<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> on aspirin or Coumadin

Medications: _____

Family History (please write in who has/had the problem - mom, dad, sister, brother)

diabetes _____ high blood pressure _____
cancer _____ heart disease _____

Surgical History (check off any surgeries you have had and write in any not on list)

<input type="checkbox"/> appendectomy	<input type="checkbox"/> hip	<input type="checkbox"/> open heart	<input type="checkbox"/> tubal ligation
<input type="checkbox"/> hysterectomy	<input type="checkbox"/> knee	<input type="checkbox"/> gall bladder	<input type="checkbox"/> cancer surgery
<input type="checkbox"/> tonsillectomy	<input type="checkbox"/> hernia	<input type="checkbox"/> cataract	<input type="checkbox"/> cardiac catheterization

Social History: __exercise __drink alcohol __smoke - how much? _____