Medical History - **Mark (X) if you currently have or have had in the past:**

Personal History
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Pacemaker
- ☐ Stroke
- ☐ Cardiac stent/Bypass Surg.________________
- ☐ Cancer

Type:________________
- ☐ Blood Clots
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Hernia

Type:________________
- ☐ Anemia

Type:________________
- ☐ Thyroid disease
- ☐ Bleeding tendency
- ☐ TB
- ☐ Diabetes
- ☐ Seizures
- ☐ Ulcers

Location:______________

General
- ☐ Loss of weight
- ☐ Loss of appetite
- ☐ Sweats
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

Skin
- ☐ Easy bruising/Bleeding
- ☐ Change in moles
- ☐ Change in hair/nail texture
- ☐ Extreme dryness
- ☐ Hives
- ☐ Eczema
- ☐ Lumps or bumps
- ☐ Rashes

Musculoskeletal:
- ☐ Back pain
- ☐ Arthritis
- ☐ Gout
- ☐ Muscle weakness
- ☐ Muscle stiffness

Eyes/Ears/Nose/Throat
- ☐ Blurred vision
- ☐ Cross eyed
- ☐ Double vision
- ☐ Eye pain
- ☐ Earache
- ☐ Ear drainage
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Runny nose
- ☐ Stuffy nose
- ☐ Postnasal drip
- ☐ Sinus problems
- ☐ Change in voice
- ☐ Difficulty swallowing
- ☐ Pain with swallowing

Lung problems
- ☐ Asthma/wheezing
- ☐ Bronchitis/pneumonia
- ☐ Dry cough.
- ☐ Productive cough
- ☐ Cough up blood
- ☐ Shortness of breath
- ☐ Oxygen use

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach pain
- ☐ Heartburn
- ☐ Nausea or Vomiting
- ☐ Rectal Bleeding
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Hemorrhoids

Urinary
- ☐ Burning on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Night time urination

Heart
- ☐ Heart palpitations
- ☐ Chest pain
- ☐ Sleep with two or more pillows
- ☐ Poor circulation
- ☐ Cholesterol
- ☐ CHF

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Memory loss
- ☐ Forgetfulness
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Irritability.

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Difficulty speaking
- ☐ Loss of coordination
- ☐ Loss of sensation
- ☐ Numbness
- ☐ Seizures
- ☐ Senility
- ☐ Tremors
- ☐ Sciatica

Vein
- ☐ Swelling of ankles or legs
- ☐ Heavy legs
- ☐ Varicose or spider veins
- ☐ Ulcers or skin discoloration

Immunizations:
- ☐ Up to date
- ☐ Tetanus date received ____________________,
- ☐ Influenza date received ____________________.
  - ☐ Not received why ____________________.
- ☐ Pneumonia date received____________,
  - ☐ Not received why ____________________.

Habits
- ☐ Smoker: packs per day or week____________.
- ☐ Former Smoker:
- ☐ Chewing tobacco user
- ☐ Former Chewing tobacco user
- ☐ Alcohol: number of glasses per day or week: ____________________.
- ☐ Exercise:______________ ____________________

Screening History
- ☐ Colonoscopy:

Date:______________

MALE:
- ☐ Prostate/PSA

Date:______________

FEMALE:
- ☐ Mammogram

Date:______________
- ☐ Pap smear

Date:______________

OB/Gyn History
- ☐ # Pregnancies:______
- ☐ # Deliveries:________
- ☐ Last Menstrual Period:______________

Family History
- ☐ Parents still living
- ☐ Mother died

age:________________

of________________
- ☐ Father died

age:________________

of________________
- ☐ Heart disease

Who:______________
- ☐ Cancer

Who______________

Type:______________
- ☐ Diabetes

Who:______________
- ☐ Anesthesia problems:
- ☐ Bleeding or Clotting Disorder:____________
- ☐ Other Family History: ____________________.

Previous Surgery/Hospitalization	Approximate Date/Facility

Current Medications – Preferred Pharmacy: ____

Medication Name	Dose	Frequency

Allergies (if there is *No Known Drug Allergies* please state NKDA)

Medication	Reaction

PATIENT NAME:______________________________**TODAY'S DATE:**________________________