

Patient Name: _____ Birth Date: _____ Patient #: _____

To help us meet all your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date: _____

Place of Birth: _____

Highest Level in School: _____

Occupation: _____

Previous Occupation: _____

Marital Status: _____

Hobbies: _____

Exercise / Recreation: _____

Habits: _____

Smoking (type and amount per day): _____

If former smoker, date quit: _____

Alcohol (type and amount per day): _____

Caffeine (type and amount per day): _____

Street Drugs (type and amount per day): _____

Usual Weight: _____

Date of Last Dental Exam: _____

Please list all allergies (foods, drugs, environment):

When was your last physical exam? _____

Name of Doctor? _____ Phone: _____

Please list all serious illnesses, operations and other hospitalizations you have experienced and indicate year these occurred: ☐ None

Please list all medicines you are currently taking (including non-prescription drugs): ☐ None

Describe all serious injuries, head injury, fractures or broken bones (include date occurred): ☐ None

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms or problems you are experiencing:

Past Medical History

Have you ever had the following? (Circle "Yes" or "No", leave blank if uncertain)

Measles	Yes	No	Migraine Headaches	Yes	No	Hives or Eczema	Yes	No
Mumps	Yes	No	Tuberculosis	Yes	No	AIDS or HIV+	Yes	No
Chickenpox	Yes	No	Diabetes	Yes	No	Infectious Mono	Yes	No
Whooping Cough	Yes	No	Cancer	Yes	No	Bronchitis	Yes	No
Scarlet Fever	Yes	No	Polio	Yes	No	Mitral Valve Prolapse	Yes	No
Diphtheria	Yes	No	Glaucoma	Yes	No	Stroke	Yes	No
Smallpox	Yes	No	Hernia	Yes	No	Hepatitis	Yes	No
Pneumonia	Yes	No	Blood or Plasma	Yes	No	Ulcer	Yes	No
Rheumatic Fever	Yes	No	Transfusion			Kidney Disease	Yes	No
Heart Disease	Yes	No	Back Trouble	Yes	No	Thyroid Disease	Yes	No
Arthritis	Yes	No	High or Low Blood	Yes	No	Bleeding Tendency	Yes	No
Venereal Disease	Yes	No	Pressure			Any Other Disease	Yes	No
Anemia	Yes	No	Hemorrhoids	Yes	No	Please list: _____		
Bladder Infection	Yes	No	Date of Last Chest X-Ray: _____					
Epilepsy	Yes	No	Asthma	Yes	No			

Family History

Have you ever had the following? (Circle "Yes" or "No", leave blank if uncertain) If "Yes", list relationship.

Cancer	No	Yes	Stroke	No	Yes
Tuberculosis	No	Yes	Epilepsy	No	Yes
Diabetes	No	Yes	Allergies	No	Yes
Heart Disease	No	Yes	Anemia	No	Yes
High Blood Pressure	No	Yes	Bleeding Tendency	No	Yes

Family History Continued

Have you ever had the following? (Circle "Yes" or "No", leave blank if uncertain) If "Yes", list relationship.

Asthma	No	Yes	_____	Present Age	If Living, Health (Good, Fair, Poor)
Chronic Lung Disease	No	Yes	_____	or Age of Death	If Deceased, Cause of Death
Drug or Alcohol Problem	No	Yes	_____		
Mental Illness	No	Yes	_____	Father: _____	
Leukemia	No	Yes	_____	Mother: _____	
Migraine Headaches	No	Yes	_____	Siblings: _____	
Obesity	No	Yes	_____		
Thyroid Disease	No	Yes	_____		
Ulcer	No	Yes	_____		
Depression	No	Yes	_____		
High Cholesterol	No	Yes	_____	Spouse: _____	
Kidney Disease	No	Yes	_____	Children: _____	
Glaucoma	No	Yes	_____		
Gout	No	Yes	_____		

Do you have now or have had within the past year: (Circle "Yes" or "No", leave blank if uncertain)

Weakness or Paralysis	Yes	No	Bloody Sputum	Yes	No	Joint Pain or Stiffness	Yes	No
Tire Easily or Weakness	Yes	No	Wheezing	Yes	No	Swollen Joints	Yes	No
Recent Weight Changes	Yes	No	Chest Pain or Discomfort	Yes	No	Muscle Cramps or Spasms		
Change in Appetite	Yes	No	Purple Fingers or Lips	Yes	No		Yes	No
Sensitivity to Cold or Heat	Yes	No	Swelling of Hands, Feet or Ankles			Sleeplessness	Yes	No
Persistent Fever	Yes	No		Yes	No	Seizures	Yes	No
Night Sweats or Hot Flashes			Difficulty in Breathing	Yes	No	Depression	Yes	No
	Yes	No	Palpitations or Fluttering of the Heart			Memory Loss	Yes	No
Skin Rash	Yes	No		Yes	No	Poor Circulation	Yes	No
Skin Trouble or Changes	Yes	No	Leg Cramps on Walking or at Night			Dizziness or Fainting Spells		
Change in Nails or Hair	Yes	No		Yes	No		Yes	No
Headaches	Yes	No	Enlarged Veins	Yes	No	A Living Will or Advance Directive		
Easy Bleeding or Bruising	Yes	No	Difficulty Swallowing	Yes	No		Yes	No
Double Vision	Yes	No	Heartburn	Yes	No	Men Only		
Blurred Vision	Yes	No	Frequent Belching	Yes	No	Discharge from Penis	Yes	No
Eye Pain	Yes	No	Abdominal Cramping	Yes	No	Pain or Lump in Testicles	Yes	No
Infected Eyes	Yes	No	Nausea	Yes	No	Impotence	Yes	No
Do you wear glasses or contacts?			Vomiting	Yes	No	Women Only		
	Yes	No	Vomited or Coughed up Blood			Age Period Began	_____	
When was your last exam?	_____			Yes	No	How many days do periods last?	_____	
Ringling in the Ears	Yes	No	Chronic Diarrhea	Yes	No	How many days between periods?	_____	
Discharge in the Ears	Yes	No	Chronic Constipation	Yes	No	Is the flow heavy?	Yes	No
Ear Pain	Yes	No	Rectal Bleeding	Yes	No	Do you bleed or spot?	Yes	No
Decrease in Hearing	Yes	No	Black Tarry Stools	Yes	No	Between Periods?	Yes	No
Frequent Nose Bleeds	Yes	No	Dark Urine	Yes	No	Do you have pain or cramps?		
Sinus Trouble	Yes	No	Yellow Jaundice	Yes	No		Yes	No
Loss of Smell	Yes	No	Frequent Urination (Day)	Yes	No	Date of Last Period?	_____	
Persistent Hoarseness	Yes	No	Frequent Urination (Night)	Yes	No	Date of Last Pelvic Exam?	_____	
Sore Throat	Yes	No	Increase in Thirst	Yes	No	Date of Last Mammogram?	_____	
Sore Tongue or Gums	Yes	No	Painful Urination	Yes	No	Any itching in vaginal areas?		
Lump or Discharge from Breast			Leakage of Urine	Yes	No		Yes	No
	Yes	No	Difficulty in Starting Urine	Yes	No	Pain with Intercourse?	Yes	No
Chronic or Frequent Cough			Blood in Urine	Yes	No	Type of birth control used?	_____	
	Yes	No	Lack of Sex Drive	Yes	No	Number of pregnancies:	_____	
Shortness of Breath	Yes	No	Hemorrhoids	Yes	No	Number of full term births:	_____	
			Backaches	Yes	No	Number of pre-term births:	_____	

X _____
Signature of Patient or Parent if Minor

Date