

Please Print Name _____ Date _____ Age _____

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so, for treatment and health care operations or by court order.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to me (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Patient Signature: _____

Physician's Review Signature: _____

Family History	If Living -Age	Health	If Deceased-age death	Cause	What is the reason for your visit? _____ _____ _____ _____
Father					
Mother					
Brother or Sister					
1.					
2.					
3.					
4.					
Spouse					
Son or Daughter					
1.					
2.					
3.					
4.					

Have you ever been advised to have any surgical operation that has not been done? Describe:

Have you been hospitalized for any illness? Details:

Past History: Please circle the conditions or illnesses you have ever had:

ALLERGIES: (Check those that apply):	Illness/Condition	Check those that apply)	
Penicillin, Sulfa, or any antibiotic	Measles		Bladder disease
Aspirin, Codeine or Morphine	German Measles		Epilepsy
X-ray contrast material	Mumps		Migraine headaches
Merthiolate, Mercurochrome, Betadine®	Chicken Pox		Tuberculosis
Nail polish or other cosmetics, latex	Whooping Cough		Cancer Type
Tetanus Antitoxin or Serums	Scarlet fever or Scarletina		Diabetes
Any foods	Diphtheria		Jaundice
Other	Smallpox		High blood pressure
	Pneumonia		Colitis or other bowel disease
	Influenza		Hemorrhoids or any rectal disease
	Pleurisy		Nervous Breakdown
	Rheumatic Fever or Heart Disease		Food, chemical or drug poisoning
INJURIES: Have you had any	Arthritis or Rheumatism		Hay fever or Asthma
Broken or cracked bones	Any bone or joint disease		Hives or Eczema
Sprains	Neuritis or Neuralgia		Frequent infections or boils
Lacerations	Bursitis, Sciatica or Lumbago		AIDS/HIV
Dislocations	Polio or Meningitis		Anemia
Concussion, or head injury	Nephritis		Gallbladder disease
Ever been knocked unconscious	Gonorrhea, Syphilis or any other STD		Deep Vein Thrombosis
Any history of gastrointestinal endoscopy?	No Yes	Family history of coagulation disorder	

Any other disease, condition, injury? Please explain

WEIGHT:

Now: _____ One Year Ago: _____ Maximum: _____ When: _____

TRANSFUSIONS: Have you ever had: Blood or Plasma Transfusion?	Year	X-RAYS: Have you ever had x-rays of:	Date
SURGERY: Have you had: Tonsillectomy Appendectomy Any other operation		Chest Stomach or colon Gall bladder Extremities	
Type		Other:	
Type		Stress Test?	
Type		Where	
Social History: Do you smoke? No Yes		EKG: Ever had an electrocardiogram?	
What tobacco products do/did you use? How many years? How many cigarettes/cigars per day?		IMMUNIZATIONS: Have you had:	
Do you drink alcohol-containing beverages? How Much?		Smallpox vaccination within last 7 yrs	
Do you use any recreational drugs? What? How Often?		Tetanus shots (not antitoxin) that lasts 2 wks	

Ever been Treated for drug habits:	N/Y	Polio shots within last 2 years			
Sex: Entirely Satisfactory?	N/Y	Ever taken insulin or tablet for Diabetes:			No Yes
Are you taking any of the following?	Never	Occ	Freq	Daily	Comments
Aspirin, etc					
Appetite depressants:					
Cortisone (steroids), ACTH:					
Thyroid					
Laxatives:					
Ever taken hormone tablets or injections: No Yes					
List medications you take on last page.					

Review of Systems: Check those which apply

Do you now have or have you had within the past year:		Any blood in bowel movement (blood in stool/toilet)	
Frequent or severe headaches		Rectal pain with bowel movement	
Fainting spells		Change in size, shape, or texture of BM	
Dizziness on change of position		Describe	
Unconscious Spells		Pain on urinating	
Blurred Vision		Difficulty in starting urination	
Double Vision		Urinate more than before	
Spots before eyes		Urinate less than before	
Infected eyes		Any blood in urine	
Pain behind eyes		Lose urine on coughing or sneezing	
Any change in vision		Do you get up at night to urinate? No Yes How often?	
Do you wear glasses		How many bed pillows do you use?	
Last eye exam? Year:		How many times per day do you urinate?	
Earaches		Full feeling of bladder, but only small amount of urination	
Ringin in ears		Hot flashes	
Decrease in hearing		Tiredness without apparent reason	
Recurrent nose bleeds		Brittleness of nails	
Recurrent head colds		Trembling of any extremity	
Sinus Trouble		Growth in neck or throat	
Hay fever		Easy bruising	
Strange persistent odors		Inability to stand heat	
Strange taste or loss in taste		Inability to stand cold	
Persistent hoarseness		Change in hair texture	
Difficulty swallowing		Change in skin texture	
Enlarged glands		Any Skin Rash	
Recurrent sore throats		Redness or heat of any joint	
Recurrent sores in mouth		Tingling or weakness of hands or feet	
Soreness or bleeding of gums on brushing		Joint Pains	
Night sweats		Swelling of any joints	
Coughed up blood		Recurrent back pains	
Chronic or frequent cough		Backaches	
Chronic or frequent cough on lying down		Muscle Spasms	
Shortness of breath		Loss or change in sensation of hands or feet	
Chest pain Angina pectoris		(Males Only) Discharge from penis No Yes	
Shortness of breath on: - Walking several blocks - One flight of stairs - Lying down		Women Only - Menstrual History Age at onset _____ Regular?	No Yes
Purple lips or fingers		Cycle _____ days (from start to finish)	
Palpitations or fluttering of heart		Flow: Heavy Medium Light	
High blood pressure		Number of pads used per period	
Swelling of hands, feet or ankles		Any clots passed No Yes	
Leg Cramps on waking or at night		Pains or cramps No Yes	
Enlarged Veins in legs		Date of last period	
Pain in arm(s)		Date of last pelvic exam	
Recurrent stomach pain		Date of last Pap test Results: Neg. Pos.	
Belching or heartburn		Any itching of vaginal area? No Yes	
- Relieved by food or medication		Any discharge from vagina? No Yes If so, color: Amount?	
- What time of day? Appetite – Good _____ Fair _____ Poor _____ Vomited blood		Do you take birth control pills? How long have you taken them?	No Yes
Nausea or vomiting		Pregnancies: Any complications with pregnancy	No Yes
Do you avoid some foods? What kinds?		Describe: How many children born alive? _____	
Do you avoid spices?		How many Cesarean Sections? _____	
Color of bowel movement		How many still births? _____ Miscariages? _____	
Abdominal cramping		How many premature births	
Print Name:			Date:

