Patient Name: _____ **Date of Birth:** _____

To help us meet all your healthcare needs, please fill out this form completely. 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 Occupations:

_____

Marital Status: _____

Hobbies: _____

Exercise/Recreation:

_____

Habits:

Tobacco (type and amount per day):

_____

If former user, date quit: _____

Alcohol (type and amount per week):

_____

Caffeine (type and amount per day):

_____

Street Drugs (type and amount per day:

_____

Usual Weight: _____

Date of last dental exam: _____

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

_____

When was your last physical exam? _____

Name of provider? Phone?

_____

Please list all serious illnesses, operations, and other hospitalizations you have experienced, and indicate the years these occurred

_____

Please list all medications you are currently taking (including non-prescription drugs:

_____

Describe all serious accidents, severe injuries, head injuries, fractures, or broken bones (include date occurred)

_____

Chief Complaint

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

_____

Past Medical History –Have you ever had any of the following? Check No or Yes

Measles	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes	Hives or Eczema	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes
Chickenpox	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Polio	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Diphtheria	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Hernia	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Back trouble	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes

Patient Name: _____

Rheumatic Fever	☐ No	☐ Yes	Blood or Plasma Transfusion	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	High or low blood pressure	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Date of last chest x-ray			Bleeding tendency	☐ No	☐ Yes
Venereal Disease	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Any other diseases	☐ No	☐ Yes
Bladder Infections	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Please List:		
Anemia	☐ No	☐ Yes						
Epilepsy	☐ No	☐ Yes						

Family History—Has any blood relative had any of the following? Check No or Yes, leave blank if uncertain

Cancer	☐ No	☐ Yes	Relation:	Stroke	☐ No	☐ Yes	Relation:	
Tuberculosis	☐ No	☐ Yes	Relation:	Epilepsy	☐ No	☐ Yes	Relation:	
Diabetes	☐ No	☐ Yes	Relation:	Allergies	☐ No	☐ Yes	Relation:	
Heart Disease	☐ No	☐ Yes	Relation:	Anemia	☐ No	☐ Yes	Relation:	
High Blood Pressure	☐ No	☐ Yes	Relation:	Bleeding Tendency	☐ No	☐ Yes	Relation:	
Asthma	☐ No	☐ Yes	Relation:	Gout	☐ No	☐ Yes	Relation:	
Chronic Lung Disease	☐ No	☐ Yes	Relation:	Glaucoma	☐ No	☐ Yes	Relation:	
Drug or Alcohol Problem	☐ No	☐ Yes	Relation:	Kidney Disease	☐ No	☐ Yes	Relation:	
Mental Illness	☐ No	☐ Yes	Relation:	High Cholesterol	☐ No	☐ Yes	Relation:	
Leukemia	☐ No	☐ Yes	Relation:	Depression	☐ No	☐ Yes	Relation:	
Migraine Headaches	☐ No	☐ Yes	Relation:	Ulcer	☐ No	☐ Yes	Relation:	
Obesity	☐ No	☐ Yes	Relation:	Thyroid Disease	☐ No	☐ Yes	Relation:	

Please list present age, or age at death for the following. If living, please list health (ie good, fair, poor). If deceased, please list cause of death:

Father:		Mother:	
Siblings:		Spouse:	
Children:			

Patient Name:

Do you have now or have you had within the past year? Check No or Yes, leave blank if uncertain

Weakness or paralysis	☐ No	☐ Yes	Bloody sputum	☐ No	☐ Yes	Joint pain or stiffness	☐ No	☐ Yes
Tire easily or weakness	☐ No	☐ Yes	Wheezing	☐ No	☐ Yes	Swollen joints	☐ No	☐ Yes
Recent weight changes	☐ No	☐ Yes	Chest pain or discomfort	☐ No	☐ Yes	Muscle cramps or spasms	☐ No	☐ Yes
Change in appetite	☐ No	☐ Yes	Purple lips or fingers	☐ No	☐ Yes	Sleeplessness	☐ No	☐ Yes
Sensitivity to cold or heat	☐ No	☐ Yes	Swelling of extremities	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Persistent fever	☐ No	☐ Yes	Difficulty in breathing	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Skin Rash	☐ No	☐ Yes	Leg cramps on walking	☐ No	☐ Yes	Memory loss	☐ No	☐ Yes
Night sweats or hot flashes	☐ No	☐ Yes	alpitations or fluttering of heart	☐ No	☐ Yes	Poor coordination	☐ No	☐ Yes
Skin trouble or changes	☐ No	☐ Yes	Enlarged veins	☐ No	☐ Yes	Dizziness or fainting spells	☐ No	☐ Yes
Change in nails or hair	☐ No	☐ Yes	Difficulty swallowing	☐ No	☐ Yes	A living will or advance directive?	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Heartburn	☐ No	☐ Yes	**MEN ONLY**		
Easy bleeding or bruising	☐ No	☐ Yes	Abdominal cramping	☐ No	☐ Yes	Discharge from the penis	☐ No	☐ Yes
Double Vision	☐ No	☐ Yes	Frequent Belching	☐ No	☐ Yes	Pain or lump in testicles	☐ No	☐ Yes
Blurred Vision	☐ No	☐ Yes	Nausea	☐ No	☐ Yes	Impotence	☐ No	☐ Yes
Eye Pain	☐ No	☐ Yes	Vomiting	☐ No	☐ Yes	**WOMEN ONLY**		
Infected Eyes	☐ No	☐ Yes	Vomited or coughed up blood	☐ No	☐ Yes	Age period began		
Do you wear glasses or contacts?	☐ No	☐ Yes	Chronic diarrhea	☐ No	☐ Yes	How many days to periods last?		
Date of Last Eye Exam			Chronic constipation	☐ No	☐ Yes	How many days between periods?		
Ringing in Ears	☐ No	☐ Yes	Rectal Bleeding	☐ No	☐ Yes	Is the flow heavy?	☐ No	☐ Yes
Discharge from ears	☐ No	☐ Yes	Black tarry stools	☐ No	☐ Yes	Do you spot or bleed between periods?	☐ No	☐ Yes
Ear pain	☐ No	☐ Yes	Dark urine	☐ No	☐ Yes	Date of last period?		
Decrease in Hearing	☐ No	☐ Yes	Yellow jaundice	☐ No	☐ Yes	Do you have pain or cramps?	☐ No	☐ Yes
Frequent nosebleeds	☐ No	☐ Yes	Frequent urination (day)	☐ No	☐ Yes	Date of last pelvic exam?		
Frequent colds	☐ No	☐ Yes	Frequent urination (night)	☐ No	☐ Yes	Date of last mammogram?		
Sinus trouble	☐ No	☐ Yes	Increase in thirst	☐ No	☐ Yes	Pain with intercourse?	☐ No	☐ Yes

Patient Name:

Loss of smell	☐ No	☐ Yes	Painful urination	☐ No	☐ Yes	Any itching in the vaginal area?	☐ No	☐ Yes
Persistent hoarseness	☐ No	☐ Yes	Leakage of urine	☐ No	☐ Yes	Type of birth control used?		
Sore throat	☐ No	☐ Yes	Difficulty in starting urine	☐ No	☐ Yes	Number of pregnancies		
Sore tongue or gums	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes	Number of full term births		
Lump or discharge from breast	☐ No	☐ Yes	Lack of sex drive	☐ No	☐ Yes	Number of preterm births		
Chronic or frequent cough	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes			
Shortness of breath	☐ No	☐ Yes	Backaches	☐ No	☐ Yes			

Printed Patient Name

Patient Date of Birth

_____

Signature of adult patient, or patient guardian

_____

Date signed

Patient Name: