



Medical History Form

Office Use Only		Office Use Only	
Date:	_____	Date:	_____
Height:	_____	Height:	_____
Weight:	_____	Weight:	_____
BP:	_____	BP:	_____
BMI:	_____	BMI:	_____
Pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Office Use Only:	Physician Signature; I have reviewed the information on this form with the patient.		
Signature: _____	Date: _____	Signature: _____	Date: _____
Signature: _____	Date: _____	Signature: _____	Date: _____

Patient Name: _____ Age: _____

What is the reason for your visit today? Date: _____

Please list all physicians that you would like to keep informed about your progress:

Referring Physician: No Yes Name: _____

Primary Care: No Yes Name: _____

Other: _____

Review of Systems: (Patient Information)

Are you currently having or have had problems with the following systems: (check & explain)

- | | | | |
|----------------------|--|--|-------|
| Constitutional | e.g. fatigue, fever, headache | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Eyes | e.g. blurred vision, glasses | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Ears, Nose, Throat | e.g. congestion, hearing loss | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Lungs, Breathing | e.g. wheezing, cough | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Heart | e.g. chest pain, heart murmurs | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Gastrointestinal | e.g. nausea, constipation, liver | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Bladder | e.g. incontinence, difficult urination | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Endocrine | e.g. diabetes, thyroid problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Musculoskeletal | e.g. joint pain, history of fractures | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Bleeding Problems | e.g. anemia, prolonged bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Neurological | e.g. numbness, tingling, dizziness | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Integumentary | e.g. rashes, skin disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Psychiatric | e.g. change in mood or behavior | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Immunologic/Allergic | e.g. asthma, chronic rashes | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |

Please list all current medications: (Prescription and/or Over-the-Counter): None

Please list all allergies: ___ None

Past Medical History

Have you ever had general anesthesia? ___ No ___ Yes

Have you had any problems with anesthesia? ___ No ___ Yes Describe: _____

Please describe any major injuries or illnesses you have had: ___ None

_____ Date _____

_____ Date _____

_____ Date _____

Please describe any surgeries you have had: ___ None

_____ Date _____

_____ Date _____

_____ Date _____

Past Family History

Relation	Alive (age)	Health Problems	Deceased (age)	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____

Social History

Occupation: _____

Disabled: ___ No ___ Yes

Retired: ___ No ___ Yes

Describe your occupation before retirement:

Marital Status: ___ Married ___ Divorced ___ Separated ___ Widowed ___ Single

Tobacco use? ___ No ___ Yes Type/amount per day/week? _____

Alcohol use? ___ No ___ Yes Amount per day/week? _____

Drug use? ___ No ___ Yes Amount per day/week? _____

The information on this form is accurate and complete to the best of my knowledge.

Patient/Parent Signature: _____ Date: _____