Patient Medical History

Name:_____ Age:_____ Date:_____
Reason For Appointment:_____
Primary Doctor:_____ Who Referred You:_____

Please list all medications including vitamins:_____

_____

Are you allergic to any medications?_____

Any previous surgeries?_____

_____

Any illnesses run in the family?_____

_____

Do you smoke or chew tobacco? Yes No How much? _____How many years?_____
Do you drink alcohol? Yes No How much? _____ How often?_____
Do you use recreational drugs? Yes No How much? _____ How often?_____
Do you take aspirin? Yes No How much? _____ How often? _____

Do you have any of the following medical problems? If yes, please explain.

Heart Disease	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Thyroid Problems	Y	N
High Cholesterol	Y	N	Rheumatic Fever	Y	N
Heart Murmurs	Y	N	Stomach Problems	Y	N
Liver Problems	Y	N	Respiratory Problems	Y	N
Arthritis	Y	N	Seizures or Epilepsy	Y	N
Blood Disorders	Y	N	Cancer	Y	N
Hepatitis	Y	N	Other:_____		

If yes to any of above please explain:

_____

_____

_____

Do you have any of the following symptoms now?

Shortness of Breath_____	Weight Loss_____	Fatigue_____
Visual Disturbance_____	Hearing Loss_____	Cough_____
Nasal Congestion_____	Sore Throat_____	Fever_____
Seasonal Allergies_____	Chest Pain_____	Weakness_____
Abdominal Pain_____	Pain on Urination_____	Numbness_____
Muscle Joint Pain_____	Hoarseness_____	Rash_____

Patient Signature:_____ Date:_____