

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

General:

Name:	Birthdate:	SS #:
Date of your last complete physical exam?		

Hospital / Surgical History:

Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

Allergies:

Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction.

Medications:

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Remember to include such things as aspirin, vitamins, laxative, calcium supplements, etc. Please include the dosage amount and the times a day you take them.

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

Social History:

Occupation:			Marital Status:		
Do you exercise regularly?	YES	NO	What type?	How often?	
Do you smoke?	YES	NO	I currently smoke	packs per day.	I have smoked for
I formerly smoked but stopped in:			(list year)	Do you wear seat belts?	YES NO
Do you use other forms of tobacco?	YES	NO	Do you use illicit drugs?	YES	NO
How often/how much?		How often/how much?		How often/how much?	
Do you have any risk factors for HIV infection?	YES	NO	Have you ever been exposed to anyone with tuberculosis?	YES	NO
Have you had excessive exposure to sun because of your work or recreation?					YES NO
Are you currently experiencing unusual stress?	YES	NO	Explain:		
Are there any environmental risks involved in your job or home environment?			YES	NO	Explain:
Women Only:	Menstrual Period Onset:	Regular?	YES	NO	Date last period began:
Birth Control Method:	Difficulty with periods?	YES	NO	Specify:	
Pregnancies: No. of children:	Born Alive:	Cesarean:	Premature:	Stillborn:	Miscarriages:
Describe complications:					
Age at menopause:	Date Period ended:		Surgical		Natural

Please turn and complete back side

Comprehensive Medical History Continued

Name:

Birthdate:

SS #:

Please check all conditions you currently have or have had:

<p>General Questions</p> <input type="checkbox"/> Tire easily/fatigue <input type="checkbox"/> Insomnia/sleep disorders	<p>Cardiovascular</p> <input type="checkbox"/> Angina <input type="checkbox"/> Leg cramps <input type="checkbox"/> Chest pain <input type="checkbox"/> Murmurs <input type="checkbox"/> Cardiac catheterization <input type="checkbox"/> Congenital heart defects <input type="checkbox"/> Heart attacks <input type="checkbox"/> High or low blood pressure <input type="checkbox"/> Irregular heart rate <input type="checkbox"/> Heart Surgery	<p>Kidneys & Urinary Tract</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent bladder infections <input type="checkbox"/> Dribbling after urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stone	<p>Respiratory</p> <input type="checkbox"/> Pleurisy <input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing <input type="checkbox"/> Prolonged cough <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Frequent infections(bronchitis)	
<p>Neurologic and Psychiatric</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Psychological problem <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Meningitis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizure <input type="checkbox"/> Stroke <input type="checkbox"/> Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Memory Loss <input type="checkbox"/> Fainting spells, dizziness <input type="checkbox"/> Head injuries <input type="checkbox"/> Blackouts or near blackouts <input type="checkbox"/> Epilepsy	<p>Musculoskeletal</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Back pain <input type="checkbox"/> Gout <input type="checkbox"/> Neck pain <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus of SLE <input type="checkbox"/> Easy bruising <input type="checkbox"/> Joint swelling <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Muscle aches <input type="checkbox"/> Bursitis <input type="checkbox"/> Joint aches <input type="checkbox"/> Tendinitis <input type="checkbox"/> Osteoprosis	<p>Endocrine</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease	<p>Gastrointestinal</p> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Reflux <input type="checkbox"/> Ulcers <input type="checkbox"/> Hepatitis <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Black or bloody stools <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Problems swallowing <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Gallstones <input type="checkbox"/> Liver disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Diverticulitis/colitis	
<p>Ears, Eyes, Nose & Throat</p> <input type="checkbox"/> Hay fever <input type="checkbox"/> Glaucoma <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Cataracts <input type="checkbox"/> Goiter <input type="checkbox"/> Double vision <input type="checkbox"/> Ear Infections <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Wear Hearing Aid <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus infections <input type="checkbox"/> Frequent sore throat	<p>Skin</p> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Athlete's foot <input type="checkbox"/> Tattoos	<p>Females Only</p> <input type="checkbox"/> D + C <input type="checkbox"/> Hernia <input type="checkbox"/> Fibroids <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Hot flashes <input type="checkbox"/> PMS <input type="checkbox"/> Endometriosis <input type="checkbox"/> Heavy bleeding during cycles <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Postmenopausal symptoms <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Vaginal warts	<p>Males Only</p> <input type="checkbox"/> Hernia <input type="checkbox"/> Prostate disease <input type="checkbox"/> Vasectomy	
				<p>Other</p> <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Tumors or growths <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcohol/drug dependency

Provider Notes

Patient Signature

Date

Guradian Signature (if under 18 years of age or required)

Date