MEDICAL HISTORY SHEET

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 form. Completion of this history allows us to provide you the most complete medical car possible. This form will be reviewed with you during your visit.

General: **Referring MD:**

Name:	Birthdate:	Today's date:

Reason for consultation:

Location of pain/problem?	How often do you have the pain?
How long have you had this problem?	How did the problem start?
What makes it worse?	What makes it better?

What associated problems have you been having?

What is the severity of your pain? Circle the appropriate number below:

(no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Past Medical History: (check those that apply)

	High blood pressure		Diabetes		Thyroid		Rheumatic Fever
	Gout		Osteoporosis		Rheumatoid arthritis		Lupus
	Blood or Plasma Tranfusions		Epilepsy		Anemia		Psoriasis
	Pneumonia		Leukemia		Emphysema		Headaches
	Stomach ulcers		Heart troubles		Stroke		Colitis
	Tuberculosis		HIV/AIDS		Depression		Jaundice
	Cancer (type)		Kidney disease				
	Other (please list):						

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. Please include the dosage amount and the times a day you take them.

1)	4)	7)
2)	5)	8)
3)	6)	9)

Social History:

Occupation:			Marital Status: S M D W					
Do you use any form of tobacco?	YES	NO	Do you use illicit drugs?	YES	NO	Do you drink alcohol?	YES	NO
How often/how much?			How often/how much?			How often/how much?		

Family History: (check those that apply)

	Thyroid		Diabetes		Asthma		Psoriasis
	Rheumatoid arthritis		Cancer		Kidney disease		Epilepsy
	Gout		Stroke		Blood problems		Spondylitis

(CONTINUED ON BACK)

	Lupus		High blood pressure		Colitis		Heart disease

Review of systems:

Please check all conditions you currently have or have had:

General Questions
- Weight loss
- Weight gain
- Change in sleep patterns
- Change in activity.capacity

Neurologic and Psychiatric
- Anxiety
- Headaches
- Depression
- Meningitis
- Paralysis
- Seizure
- Stroke
- Tingling
- Tremors
- Memory Loss
- Fainting spells, dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere on your body
- Localized weakness or numbness

Ears, Eyes, Nose & Throat
- Dry eyes
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Hoarseness
- Double vision
- Gum problems
- Eye problems
- Ear Infections
- Glasses/contacts
- Hearing Loss
- Ear discharge/pain
- Frequent nosebleeds
- Ringing in your ears
- Sinus infections
- Swollen glands
- Dry mouth

Cardiovascular
- Angina
- Chest pain
- Leg cramps
- Murmurs
- Ankle swelling
- Awakening at night short of breath & getting out of bed
- Cardiac catheterization
- Cold hands or feet
- Congenital heart defects
- Dizziness when standing up quickly
- Heart attacks
- Heart failure
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Varicose veins

Respiratory
- Pleurisy
- Wheezing
- Asthma
- Breathlessness lying flat
- Prolonged cough
- Coughing up blood
- Emphysema
- Shortness of breath
- Tuberculosis
- Pneumonia
- Frequent infections(bronchitis)

Skin
- Abscess
- Dandruff
- Acne
- Oily skin
- Boils
- Rashes
- Hives
- Dry skin
- Lumps
- Psoriasis
- Jaundice
- Athlete's foot
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles- irregular
- Moles - change/new

Kidneys & Urinary Tract
- Blood in urine
- Brown urine
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/incontinence
- Urinating frequently (day)
- Urinating frequently (night)
- Urine hesitancy
- Weak flow
- Frequent bladder infections
- Kidney disease
- Kidney stone

Endocrine
- Diabetes
- Sickle cell
- Abnormal body hair
- Changes in skin texture
- Cold intolerance
- Heat intolerance
- History of "borderline" diabetes
- Increased loss of hair
- Rheumatism
- Thyroid disease

Male & Female
- Painful sexual intercourse
- Loss of sexual interest
- Unprotected sex
- Groin itching
- Sexually transmitted diseases

Males Only
- Hernia
- Penile discharge
- Prostate disease
- Sores on penis or warts
- Testicular pain
- Testicular swelling

Musculoskeletal
- Anemia
- Arthritis
- Back pain
- Bursitis
- Gout
- Joint aches
- Neck pain
- Tendinitis
- Abnormal Blood Counts
- Blood clots in legs/lungs
- Bone Marrow Biopsy
- Easy Bleeding
- Easy bruising
- Joint swelling
- Morning stiffness
- Muscle aches

Gastrointestinal
- Diarrhea
- Gallstones
- Reflux
- Vomiting
- Ulcers
- Heartburn
- Hepatitis
- Indigestion
- Abdominal pain
- Anal fissures
- Black tarry stools
- Vomiting blood
- Constipation
- Nausea
- Problems swallowing
- Hiatal Hernia
- Intestinal obstruction
- Liver disease
- Hemorrhoids
- Red blood after bowel movements

Females Only
- Menopause
- Hot flashes
- Hernia
- Fibroids
- Abn. bleeding between cycles
- Miscarriages
- Complications w/ pregnancy
- PMS
- Endometriosis
- Heavy bleeding during cycles
- Discharge from breast
- Ovarian cysts
- Pelvic Inflammatory Disease
- Postmenopausal symptoms
- Vaginal discharge
- Vaginal Dryness
- Vaginal warts

Provider Notes