

**Past and Current Medical History**

Have you (the patient) been diagnosed with any of the following? Check all that apply.

Cancer:	Heart	Renal	Other: (List)
Breast <input type="checkbox"/>	Heart Disease/Heart Attack <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>	
Lung <input type="checkbox"/>	Congestive Heart Failure <input type="checkbox"/>	Renal Failure <input type="checkbox"/>	
Skin <input type="checkbox"/>	Peripheral Vascular Disease <input type="checkbox"/>	Urine Leakage <input type="checkbox"/>	
Throat <input type="checkbox"/>	Angina/Chest Pain <input type="checkbox"/>		
Prostate <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>		
		<b>Bone</b>	
		Osteoporosis <input type="checkbox"/>	
		Recent Fractures <input type="checkbox"/>	
		Fibromyalgia <input type="checkbox"/>	
		Osteoarthritis <input type="checkbox"/>	
		Lupus <input type="checkbox"/>	
		Rheumatoid arthritis <input type="checkbox"/>	
<b>Mental Health</b>	<b>Blood</b>	<b>Breathing</b>	
Anxiety <input type="checkbox"/>	Blood Clots/DVT <input type="checkbox"/>	Asthma <input type="checkbox"/>	
Depression <input type="checkbox"/>	Anemia <input type="checkbox"/>	Breathing Difficulties <input type="checkbox"/>	
Memory Problems <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	COPD <input type="checkbox"/>	
Bipolar Disorder <input type="checkbox"/>	Bleeding Problems <input type="checkbox"/>	Black Lung <input type="checkbox"/>	
ADHD <input type="checkbox"/>			
	<b>GI</b>	<b>Endo</b>	
<b>Brain</b>	Nausea/Vomiting <input type="checkbox"/>	Diabetes <input type="checkbox"/>	
Migraine/Headache <input type="checkbox"/>	GERD/Reflux <input type="checkbox"/>	High/Low Thyroid <input type="checkbox"/>	
Hearing Loss <input type="checkbox"/>	Special Diet Needs <input type="checkbox"/>		
Stroke/CVA <input type="checkbox"/>	Stomach Ulcer <input type="checkbox"/>	<b>Skin</b>	
Seizures <input type="checkbox"/>	Hernia <input type="checkbox"/>	Eczema <input type="checkbox"/>	
Sleep Apnea <input type="checkbox"/>	IBS <input type="checkbox"/>	Acne <input type="checkbox"/>	
Dizziness <input type="checkbox"/>	Liver Disease <input type="checkbox"/>		
Fainting <input type="checkbox"/>	IBD <input type="checkbox"/>		
Ringling in ears <input type="checkbox"/>			

**For Pediatric Patients only**

Immunizations up-to-date?  Yes  NO If Yes, where: Office Name: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

Concerns for growth and development?  Yes  No If Yes, please specify \_\_\_\_\_

Please Check all that apply:

Chicken pox <input type="checkbox"/>	Fractures <input type="checkbox"/>	Overactive <input type="checkbox"/>	
Measles (Rubeola) <input type="checkbox"/>	Operations <input type="checkbox"/>	Impulsive <input type="checkbox"/>	
Rubella <input type="checkbox"/>	Contusions <input type="checkbox"/>	Lacking in self control <input type="checkbox"/>	
Meningitis <input type="checkbox"/>	Anemia <input type="checkbox"/>	<b>Problems with:(check all that apply)</b> Peers <input type="checkbox"/> Siblings <input type="checkbox"/> Parents <input type="checkbox"/> Sleep <input type="checkbox"/> Attention <input type="checkbox"/> School <input type="checkbox"/> Mood <input type="checkbox"/>	
Convulsions <input type="checkbox"/>	iron deficienc <input type="checkbox"/>		
Blood Transfusions <input type="checkbox"/>	Sickle Cell <input type="checkbox"/>		
Poison Ingestion <input type="checkbox"/>	Mumps <input type="checkbox"/>		
Bed wetting <input type="checkbox"/>			

Any other concerns you would like to discuss today? \_\_\_\_\_

Other serious medical issues:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History**

Tobacco Use:  Current  Past  Never If **Yes, how much:** \_\_\_\_\_ packs per day  Quit : Year \_\_\_\_\_  
 Alcohol:  **NO**  YES : How much? \_\_\_\_\_ Drinks per week  
 Recreational \_\_\_\_\_

Occupation \_\_\_\_\_  Retired  Disabled  Student  Minor

**Home Living Situation (Check all that apply)**

Alone  With mother  With father  With spouse  With siblings  With children  In nursing home  In assisted living  In foster care  With significant other  other

**Family History:** Check which family members have had the following:

	None	Mother	Father	Sister	Brother	Other
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Allegries : Are you allergic to any of the following? Check all that apply.  **NONE**

	Name of medication	What happens when you take this medication?
1		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other
2		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other
3		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other
4		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other
5		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other
6		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Other

**Current Medications:**  **NONE**

	Name of medication	Strength (mg)	How many times a day?	Reason for taking
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Past surgical History: (Include all operations that you have had)**

	Name of operations	Date	Reason	Hospital	Surgeon
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

This form was completed by \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient  Self  Mother  Father  Daughter  Son  Other (specify) \_\_\_\_\_