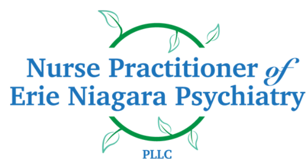

MEDICAL HISTORY

NAME: ________________________________ DATE: ________________

Are you allergic to any medication? YES NO

PAST MEDICAL HISTORY

Diabetes__ Osteoporosis__ Blood clots__ Chest Pain/Angina__

Asthma/COPD__ Peripheral Vascular Disease__ High Blood Pressure__

Stroke CVA/TIA__ Tuberculosis__ Heart Disease__ Seizure__

Heart Attack__ HIV/AIDS__ Congestive Heart Failure__ High Cholesterol__

Hepatitis__ Thyroid Disease__ Pacemaker__ Stomach Ulcer__

Headaches__ Liver Disease__ Kidney Stones__ Palpitations__

Kidney disease__ Arthritis__ Cancer__ Heart Surgery__

Other: ____

ROS		Please check all CURRENT positive findings
Constitutional		Wt loss__ Fever__ Chills__ Poor Appetite__ Fatigue__ Weight gain__ Insomnia__ Night Sweats__
Eyes		Blurry vision__ Eye Pain__ Eye redness__ Decrease in vision__ Dry Eyes__ Double vision__
ENT		Sore Throat__ Hoarseness__ Ear pain__ Hearing loss__ Ear discharge__ Nose bleed__ Tinnitus__ Sinus__
Cardiovascular		Chest pain__ Palpitations__ Rapid Heart rate__ Heart murmur__ Poor circulation__ Swelling legs/feet__
Respiratory		Shortness of breath__ Chronic cough__ Coughing up blood__ Hx of tuberculosis__ Excess sputum__
Gastrointestinal		Nausea__ Vomiting__ Diarrhea__ Constipation__ Blood in stool__ Frequent heartburn__ Trouble swallowing__
Skin		Rash__ Hives__ Hair loss__ Skin sores__ itching__ skin thickening__ Nair changes__ Mole changes__
Musculoskeletal		Joint pain__ Muscle aches__ leg cramps__ Muscle weakness__ Bone pain__ Joint swelling__ Back pain__
Psychiatric		Anxiety__ Depression__ Alcohol/drugs dependence__ Suicidal thoughts__ Panic attacks__ Depression__
Endocrine		Goiter__ Heat intolerance__ Cold intolerance__ Increased thirsts__ Change is skin color__ Excess sweating__
Neurological		Seizure__ Tremors__ Migraines__ Numbness__ Dizzines/vertigo__ Loss of balance__ Slurred speech__ Stroke__
Hem/lymphatic		Low blood count__ Easy bruising__ Swollen lymph nodes__ Transfusions__ Bleeding__ Blood clots__
Allergic/immun		Allergic reaction__ Hay fever__ Frequent infections__ Hepatitis__ HIV positive__ Positive tuberculine test__
Social History:		Marital status__________________ Occupation ____ Non smoker _____ Former smoker_____ Current smoker____ How many cigarttes per day_________ Alcohol: Never_____ 2-4 drinks per week____ 2 or more drinks per day____ weekend drinking____ Occasional drinking_____ Binge drinking (more than four drinking at one time)____
Family History: List any medical problems		Father:_____________________ Mother:_____________________ Siblings_____________________ Children:_____________________
Additional information:		

Signature of Reviewing Prescriber: ______________________________ Date:____________________