

PATIENT NAME: \_\_\_\_\_

Your answers on this form will help your clinician understand your medical concerns and conditions better. Please be as specific as possible. Estimates are fine if you cannot remember specific details. **Thank you!**

MEDICATION	DOSE

DRUG ALLERGIES	REACTION

\*Please include shellfish and eggs

**PERSONAL MEDICAL HISTORY:** Please indicate (✓) if you have had any of the following medical problems.

Congenital heart disease		Diabetes*		Depression	
Heart Attack		Thyroid Disorders*		Alcoholism/substance abuse	
High Blood Pressure		Bleeding Disorders*		Communicable Diseases*	
High Cholesterol		Autoimmune Disorders*		Birth Defect/Genetic Disease*	
Stroke		Cancer*		Other*	

\* Please specify type: \_\_\_\_\_

\*Local MD: \_\_\_\_\_ Phone # \_\_\_\_\_ Last seen: \_\_\_\_\_

**SURGICAL HISTORY:** Please list all surgeries and dates.

SURGERY	DATE

**IMMUNIZATIONS:** Please indicate if you have received the following immunizations.

Tetanus (TDAP or TD) Year \_\_\_\_\_ Pneumovax (pneumonia) Year \_\_\_\_\_ Shingles Year \_\_\_\_\_

**SOCIAL HISTORY**

**TOBACCO:** Cigarettes[ ] Cigars[ ] Pipe[ ] Snuff/Chew[ ] Packs/day \_\_\_\_\_ Number years \_\_\_\_\_  
 Quit date: \_\_\_\_\_ Are you interested in quitting? Yes[ ] No[ ]

**ALCOHOL:** Do you drink alcohol? Yes[ ] No[ ] Number of drinks/week \_\_\_\_\_  
 Is alcohol use a concern for you or others? Yes[ ] No[ ]

**DRUG USE:** Do you use any recreational drugs? Yes[ ] No[ ] Have you ever used needles? Yes[ ] No[ ]

**REVIEW OF SYSTEMS:** Please indicate (√) any current problems you have on the list below.

Fever/chills/sweats		Cough/wheezing		Mole changes	
Unexplained weight loss/gain		Difficulty breathing		Headaches	
Fatigue/weakness		Abdominal pain		Dizziness/light headedness	
Excessive thirst/urination		Blood in stool		Numbness	
Change in vision		Nausea/vomiting/diarrhea		Memory loss	
Difficult hearing/ringing in ears		Night time urination		Loss of coordination	
Problems with teeth/gums		Leaking urine		Anxiety/stress	
Hayfever/allergies		Unusual vaginal bleeding		Problems with sleep	
Chest pain/discomfort		Discharge: penis or vagina		Depression	
Leg pain with exercise		Sexual function problems		Unexplained lumps	
Palpitations		Muscle/joint pain		Easy bruising/bleeding	
Breast lump/discharge		Rash		Other*	

\*Please specify \_\_\_\_\_

### FAMILY HISTORY

Please indicate (√) family members who have had any of the following conditions.

MEDICAL CONDITION	PARENT	CHILD	SIBLING	GRAND PARENT
Alcoholism				
Anemia				
Autoimmune disorders*				
Problems with numbing medication				
Arthritis				
Asthma				
Bleeding problems				
Cancer*				
Depression				
Diabetes*				
Eczema				
Epilepsy/seizures				
Glaucoma				
Hay fever/ allergies				
Hearing problems				
Heart attack				
High blood pressure				
High cholesterol				
Kidney disease				
Liver disease				
Migraines/headaches				
Mitral valve prolapsed				
Osteoarthritis				
Osteoporosis				
Stroke				
Thyroid*				
Other*				

\*Please specify type \_\_\_\_\_