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MEDICAL HISTORY

Name:______________________________ Date of Birth:______________Age:______

Reason for Visit:____

Medical History	
Do you take Aspirin ◻ Yes ◻ No	Other blood thinners ◻ Yes ◻ No
Medications for your Immune System ◻ Yes ◻ No	

List Medications with dosages: (◻ Check here if providing a separate list of medications with the dosages)

______________________ ______________________
______________________ ______________________
______________________ ______________________

Allergies: ______________________________ LATEX Allergy ◻ Yes ◻ No

Medical Illnesses		
High blood pressure	◻ Yes	◻ No
Heart disease/Heart attack	◻ Yes	◻ No
Diabetes	◻ Yes	◻ No
Asthma	◻ Yes	◻ No

List any not mentioned:

______________ ______________
______________ ______________
______________ ______________
______________ ______________

Surgical History		
List your surgeries	Surgeon	Approx Date
Have you ever had a colonoscopy?	◻ No	◻ Yes: Year ________

Other History

Smoking ◻ No ◻ Quit. How long ago? ________ ◻ Yes. How much? ______________
Alcohol ◻ No ◻ Quit. How long ago? ________ ◻ Yes. How much? ______________
Work ◻ No ◻ Disabled ◻ Retired ◻ Yes. Occupation: ______________ / Heavy lifting ◻ Yes ◻No

Family History

Heart disease/Heart Attack: ◻ No ◻ Yes, relationship:______________________
Diabetes: ◻ No ◻ Yes, relationship:______________________
Cancer: ◻ No ◻ Yes, relationship:______________________
Other: ____________________

Past Tests

Have you had any of the following in the past year:

Chest XRAY	◻ Yes	◻ No	CT scan	◻ Yes	◻ No	Mammogram	◻ Yes	◻ No
EKG	◻ Yes	◻ No	Ultrasound	◻ Yes	◻ No	Blood Tests	◻ Yes	◻ No

(turn over)

Name:____

REVIEW OF SYSTEMS

(non-selection will be taken to mean absence of the symptom)

General	**NONE APPLY**
□fatigue □fever □night sweats □weight gain more than 10 lbs □weight loss more than 10 lbs	□
Skin	
□change in wart/mole □itching □new lesions □rash	□
HEENT	
□headache □visual disturbance □hearing loss □frequent colds □bleeding gums □hoarseness	□
Neck	
□swollen glands	□
Respiratory	
□cough □difficulty breathing □snoring □sleep apnea	□
Breast	
□breast mass □breast pain □nipple discharge □breast cancer	□
Cardiovascular	
□chest pain □elevated blood pressure □shortness of breath □swelling of extremities □leg pain/swelling	□
Gastrointestinal	
□abdominal pain □constipation □diarrhea □difficulty swallowing □bloating □nausea □vomiting □heartburn □rectal bleeding	□
Female GU (females only)	
□absence of menstruation □incontinence □irregular menstruation □painful urination □ pelvic pain □urgency □vaginal bleeding □vaginal discharge	□
Male GU (males only)	
□frequency □incontinence □urination at night □testicular mass □testicular pain	□
Musculoskeletal	
□calf pain □joint pain □muscle cramps	□
Neurological	
□dizziness □weakness	□
Psychiatric	
□anxiety □depression	□
Endocrine	
□cold intolerance □excessive thirst □excessive urination □thyroid problems	□
Hematology	
□anemia □enlarged lymph nodes □prolonged bleeding	□

The above has been filled to the best of my knowledge ______________________________ ____________

(patient and/or caregiver signature) (date)

The above has been reviewed and confirmed with the patient. ______________________________ ____________

(physician signature) (date)