MEDICAL HISTORY – PAGE 1 DATE: _____

PATIENT NAME: _____D/O/B: _____

Chief Complaint/symptoms:_____

_____

Age:_____ Ht.: _____ Wt.: _____ Occupation:_____

Allergic to Medicine? Reaction?:_____

_____

When was your last medical exam?_____By Whom:_____

Past Medical History/Review of Systems

Childhood diseases?_____

Accidents/injuries?_____

Any surgery & when?_____

Any hospitalizations & when?_____

Have you ever had or are you having any of the following problems?

Please circle and explain.

Skin, hives	Y	N	_____
Head, headaches	Y	N	_____
Eye problems	Y	N	_____
Ear	Y	N	_____
Nose, sinus	Y	N	_____
Throat, mouth	Y	N	_____
Thyroid, neck	Y	N	_____
Lungs, asthma, bronchitis	Y	N	_____
Heart-chest pains, other	Y	N	_____
Circulatory, bleeding	Y	N	_____
GI, stomach, bowel, liver	Y	N	_____
OB, GYN, Prostate	Y	N	_____
Kidney, urinary, bladder	Y	N	_____
Bones, joints, arthritis	Y	N	_____
Autoimmune, Endocrine	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
High Blood Pressure	Y	N	_____
Anxiety, depression	Y	N	_____
Neurology	Y	N	_____

MEDICAL HISTORY - PAGE 2 DATE: _____

Patient's Name: _____D/O/B:_____

Family History Please list all relatives who have definite illnesses; if deceased, please give reason and age at the time of death.

Father: _____

Mother: _____

Grandmother/Grandfather: _____

Aunt/Uncle: _____

Sisters/Brothers: _____

Have you or anyone in your family ever had problems with anesthesia? **Y** **N** If so, please describe: _____

Social History

Do you or did you smoke? Y N If so, how much? If quit, when? _____

Do you or did you do street drugs? Y N If so, how much? If quit, when? _____

Do you or did you drink alcohol? Y N If so, how much? If quit, when? _____

Do you or did you coffee/caffeine? Y N If so, how much? If quit, when? _____

Do you have allergies? Y N seasonal? Y N food? Y N animals? Y N

Explain allergies: _____

Circle the correct answers to describe your residence/workplace.

Type of Dwelling:

House Apartment Condominium Dormitory Mobile/Motorhome

Location of Dwelling:

Farm City Country Mountain Other

Age of Dwelling: _____years Built: _____ Years of occupancy:_____

Heating: Solar Wood Forced Air Electric Hot water (radiators) Radiant (in floor)

Air conditioning: Y N central or room Humidifier Y N Type: _____

Air Filtration: Y N central or room Type: _____

Bedroom Floor Coverings: Carpet Wood Cement Linoleum/tile

Bed Mattress: Conventional Water Allergen encasement Air Age in years: _____

Indoor Animals: None Cat # _____ Dog # _____ Bird #_____ Other: _____

Outdoor Animals: None Cat # _____ Dog # _____ Horse # _____ Other: _____

Smoker(s) in residence: Y N Relationship to you: _____

Smoker(s) in workplace: Y N Smoker(s) in daycare (if child): Y N