

Name: \_\_\_\_\_

Date: \_\_\_\_\_



### PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

#### PRIOR MEDICAL HISTORY

Operations: Type & Date (for each) \_\_\_\_\_

Hospitalizations: Type & Date (for each) \_\_\_\_\_

Please List Doctors You've Seen in the Last 5 Years: \_\_\_\_\_

Are you Allergic to any Medications? Yes  No

If Yes, Please List \_\_\_\_\_

Please Check Yes or No if You've Ever Had Any of the Following:

(If Yes, Also Circle the Specific Condition)		NO	YES	MD ONLY
<b>Heart</b>	Chest Pain, Pressure or Discomfort			
	Discomfort in Neck, Throat, Jaw, Shoulders, Upper Back or Arms			
	Unexpected Shortness of Breath			
	Change in Level of Endurance - "poor endurance"			
	Palpitation (Skipping or Racing Heart)			
	Passing Out (or nearly passing out)			
	Heart Murmur / Rheumatic Fever / Pericarditis			
	High Blood Pressure (Hypertension)			
	Diabetes			
	High Cholesterol			
	Stroke, TIA (mini-stroke)			
	Have you ever smoked? Y / N If Yes: Number of Years _____ Have you Quit? _____ When? _____			
<b>GYN</b>	Have you experienced Menopause? Y / N If Yes, Age of Onset _____			
	<b>General</b>	Fatigue		
Appetite Problems? Y / N      Current Weight _____ Weight Loss: _____      Gain _____				
Poor Sleep (Insomnia)				
Cold, Discolored Fingers				
Depression, Mental Health Concerns				
Cancer				

PLEASE CONTINUE ON THE OTHER SIDE

Name:

Date:



### PATIENT MEDICAL HISTORY

(If Yes, Also Circle the Specific Condition)		NO	YES	MD ONLY
<b>Head</b>	Vision Problems			
	Hearing Problems			
<b>Neck</b>	Thyroid Problems			
	Neck Arthritis, Disc Problem, Whiplash Injury			
<b>Lungs</b>	Airway Obstruction, Asthma, Wheezing			
	Chronic Bronchitis, Emphysema, TB, Blood Clots (pulmonary embolism)			
<b>Digestive</b>	Swallowing Problem			
	Indigestion, Heartburn, Reflux, Hiatal Hernia, Belching Ulcer, Bleeding			
	Liver Problems, Hepatitis, Jaundice, Gall Stones			
	Blood in Bowel Movements - Red or Black			
	Diarrhea, Constipation			
<b>Urology</b>	Kidney or Prostate Problems			
	Infections, Bleeding, Kidney Stones			
<b>Legs</b>	Swelling			
	Cramping with walking			
	Blood Clots, Varicose Veins			
<b>Joints</b>	Arthritis			
	Low Back Pain			
<b>Skin</b>	Rash, Cancer			
<b>Blood</b>	Bleeding or Clotting Problem			
	History of Transfusions?			

**Family History:** Please list major heart and circulatory problems of your family - Angina, Heart Attack, Poor Circulation, High Blood Pressure, Diabetes, Stroke, Irregular Heart Beat, Sudden Death, etc.

<u>Father</u>	<u>Mother</u>	<u>Brothers/Sisters</u>	<u>Grandparents/Other</u>

What work do/did you do? \_\_\_\_\_ Retired? Y / N

Do you live with anyone? Y / N Whom? \_\_\_\_\_

Do you have Children? Y / N Ages(s) \_\_\_\_\_ Do any live locally? Y / N

Please describe your physical activities \_\_\_\_\_

Please Describe your stress level \_\_\_\_\_

Number of alcoholic beverages consumed per week \_\_\_\_\_

Additional problems or things we should know about \_\_\_\_\_