MEDICAL HISTORY RECORD

Today's Date: _____

All information is treated as confidential unless you grant permission to release.

Name: **Birthdate:**

FAMILY HISTORY	IF LIVING Age	IF LIVING Health (good, fair, or poor)	IF DECEASED Death Age	IF DECEASED Death Cause
Father				
Mother				
Brothers/Sisters **(circle sex)**				
1.) M F				
2.) M F				
3.) M F				
4.) M F				
5.) M F				
Husband □ Wife □				
Sons/Daughters **(circle sex)**				
1.) M F				
2.) M F				
3.) M F				
4.) M F				
5.) M F				

SOCIAL HISTORY

Please check all that apply to you & amount that you consume/use

□ Smoke _____ Pack(s) per day
For how long? _____

□ Chewing tobacco _____ Cans per day
For how long? _____

□ Drink caffeine
How much? _____

□ Drink alcohol
How much? _____

□ Illicit drug use?

Any blood relatives who have or have had any of the listed conditions

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
Anxiety				Congenital Heart				Leukemia			
Asthma				Depression				Migraine			
Arthritis				Diabetes				Obesity			
Allergies				Epilepsy				Rheumatism			
Anemia				Goiter				Rheumatic Fever			
Alcoholism				High Blood Pressure				Stroke			
Bleeding Tend.				Heart Disease				Stomach Ulcers			
Cancer				Hay Fever				Suicide			
Colitis				Kidney Disease				Tuberculosis			

Operations you have had	Year	Illnesses you have had requiring hospitalization	Year	Serious illness not requiring hospitalization	Year
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Drugs you are allergic to:

_____
_____
_____
_____
_____

Describe any serious injuries or accidents you have had

_____
_____
_____
_____
_____

WOMEN ONLY	Yes	No
Are you still having regular monthly menstrual periods:	□	□
Have you ever had bleeding between your periods?	□	□
Are you currently or have you ever been any form of birth control?	□	□
If yes, what kind? _____		
Have you ever had a miscarriage?	□	□
Have you ever had discharge from the nipple of your breast?	□	□
Do you have a routine gynecological exam?	□	□
First day of your last menstrual period? _____		

MEN AND WOMEN	Yes	No
Do you frequently have severe headaches?	□	□
(if yes, answer the following)		
Do they cause visual trouble?	□	□
Do they occur on one side of the head?	□	□
Do they awaken you at night from your sleep?	□	□
Do they feel like a tight had band?	□	□
Do they hurt most in the back of the head and neck?	□	□
Does aspirin or Tylenol help headache?	□	□

Have you recently had pain in the stomach which:	Yes	No
Occurs 1-2 hours after a meal?	☐	☐
Is brought on by eating fried or greasy foods?	☐	☐
Awakens you at night?	☐	☐
Is relieved by antacid medications?	☐	☐
Is relieved with milk or eating?	☐	☐
Occurs while eating or immediately after?	☐	☐
Is relieved by a bowel movement?	☐	☐
Causes loss of appetite?	☐	☐

Have you ever had any shortness of breath	Yes	No
Doing your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up sputum?	☐	☐

Have you ever had pain or tightness in your chest which begins:	Yes	No
When exerting yourself?	☐	☐
When walking against a wind?	☐	☐
When walking up a hill?	☐	☐
After a heavy meal?	☐	☐
When upset or excited?	☐	☐
When walking in cold weather?	☐	☐
When walking fast?	☐	☐
Do you sleep on more than one pillow?	☐	☐

Have you ever had pain or tightness in your chest that:	Yes	No
Caused palpitations?	☐	☐
Radiates down your arm?	☐	☐
Disappears if you're at rest?	☐	☐
Occurs only at rest?	☐	☐

If you have any other chest pain or tightness, please explain: _____

Neurological	Yes	No
Have you ever fainted?	☐	☐
Spells of dizziness?	☐	☐
Ringing in ears?	☐	☐
Double vision?	☐	☐

	Yes	No
Pain in ear?	☐	☐
Nosebleeds?	☐	☐
Spells of weakness of arm or leg?	☐	☐
Have you ever had a seizure?	☐	☐

Do you frequently have:	Yes	No
Bleeding gums?	☐	☐
Trouble swallowing?	☐	☐
Hoarseness?	☐	☐
A sore throat?	☐	☐
Nausea and vomiting?	☐	☐

Have you had:	Yes	No	When or since when?
Burning when urinating?	☐	☐	_____
Loss of control of bladder?	☐	☐	_____
Blood in your urine?	☐	☐	_____
Dark colored urine?	☐	☐	_____
Trouble starting to urinate?	☐	☐	_____
Trouble holding your urine?	☐	☐	_____
Passed a kidney stone?	☐	☐	_____
Do you get up frequently at night?	☐	☐	_____

Have you recently had:	Yes	No	When or since when?
Pains in calves of legs when walking?	☐	☐	_____
Cramps in legs at night?	☐	☐	_____
Pain in the big toe?	☐	☐	_____
Varicose veins?	☐	☐	_____
Swelling of the ankles?	☐	☐	_____

Bowel Issues - Have you had:	Yes	No	When or since when?
Crampy pain in the abdomen?	☐	☐	_____
Alternating diarrhea and constipation?	☐	☐	_____
Pain during or after bowel movements?	☐	☐	_____
Mucous in the stool?	☐	☐	_____
Blood in the stool?	☐	☐	_____
Ribbon-like stools?	☐	☐	_____
Black stools?	☐	☐	_____
Require use of strong laxatives or enemas?	☐	☐	_____

Describe briefly your present medical symptoms and anything else we should know about your health.