

# PATIENT MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for Visit \_\_\_\_\_

**Office Use Only**

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Temp \_\_\_\_\_

## Previous Surgery

	Yes	Date	Comments
Anesthesia Problem			
Bladder/Kidney			
Appendix			
Breast			
Colon/Intestine			
Gallbladder			
Gynecologic			
Heart/Lung			
Hernia			
Liver			
Orthopedic			
Spleen			
Stomach			
Thyroid			
Other			

## Medical Disorders

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Infections          | <input type="checkbox"/> Kidney Stones        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Cancer, Any Type |
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Urinary Infections   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Colitis/Crohn's    | <input type="checkbox"/> Migraines        |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Hemorrhoids        | <input type="checkbox"/> Mental Illness   |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Strokes        | Comments: _____                             |   |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Diverticulitis |   |   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> GERD, Reflux   | Additional Information: _____               |   |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Blood Clot           | <input type="checkbox"/> Ulcers         |   |   |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Liver Disease  |   |   |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Depression     |   |   |

## Medications & Herbal Supplements

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Allergies

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Social Habits

- Tobacco Daily Amount \_\_\_\_\_
- Alcohol Daily Amount \_\_\_\_\_
- Caffeine Daily Amount \_\_\_\_\_
- Other \_\_\_\_\_

## Family History

	Alive	Deceased	Medical Problems	Cause of Death
Father				
Mother				
Brothers	#	#		
Sisters	#	#		
Children	#	#		