



## PATIENT MEDICAL HISTORY & PROBLEMS LIST

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status \_\_\_\_\_

**Drug Allergies:** (Please indicate by checking the boxes below.)

**NO KNOWN DRUG ALLERGIES**

Local anesthetics (Novocain etc.)  Penicillin  Keflex  Erythromycin  Other antibiotic: \_\_\_\_\_

Sulfa drugs  Aspirin  Narcotics (codeine, morphine etc.)  Other painkillers (Percocet, Oxycontin etc.)

Latex  Eggs/Yolk  Sulfites  Tetracycline  Iodine/shellfish  NSAIDs (Ibuprofen etc.)

Please specify any others: \_\_\_\_\_

Please specify type of reaction: \_\_\_\_\_

**Medicines:** (Please list any medications or supplements that you take **REGULARLY**, with dose/frequency.)

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

### **Social Habits:**

*Alcohol*- Do you use alcohol? \_\_\_\_\_ How much? \_\_\_\_\_/week. If you quit, when? \_\_\_\_\_

*Tobacco*- Do you smoke or use tobacco products? \_\_\_\_\_ How much? \_\_\_\_\_/day.

Number of Years using \_\_\_\_\_ If you quit, when? \_\_\_\_\_

*Illicit Drugs* – Do you use illicit drugs? \_\_\_\_\_

**\*** *Have you or a family member ever been diagnosed with a blood clot in a leg or a lung?* \_\_\_ YES \_\_\_ NO

**Medical Conditions:** (Please circle any of the listed medical conditions that you have been or are currently being treated for. Detail below.)

Neurologic Problems   Migraines   Seizures   Stroke   Carpal Tunnel   High Blood Pressure

Heart Attack   Irregular Heart Beat   Heart Murmur   Kidney or Bladder Problems   Gout

Kidney Stones   Diabetes   Prostate Problems   Thyroid Problems   Hepatitis   Cirrhosis

Anemia   Pneumonia   Emphysema   Tuberculosis   Cancer   Hiatal Hernia

Asthma   Pregnancy (include # pregnancies and # of deliveries)   Broken Bones   Ligament or Tendon Injury

Joint Problems   Ulcers   Anxiety   Depression   Other Condition Not Listed: \_\_\_\_\_

Please list Surgeries/Complications/Diagnoses along with the DATE:

<u>Surgery</u>	<u>Year</u>	<u>Complications</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

<u>Medical Problems</u>	<u>Year</u>	<u>Complications</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

**Family History:**

Is there a history of any of the following conditions in your family?

Please circle and state which family member is/was effected. Detail below:

Diabetes    Heart Attacks    Cancer    Kidney Problems    Problems with Anesthesia    Arthritis  
 Bleeding/Clotting Problems    Other Inherited Diseases

**Review of Systems:**

Have you experienced any of the following in the **last few weeks or months?**

Please circle the complaint and detail below. If you have no complaints in a category, please circle "NONE"

General:	fever    chills    swollen glands    loss of memory    weakness    aches/pains    weight loss/gain	NONE
Headaches:	Yes	NONE
Eyes:	double vision    blurry vision    eye pain	NONE
Ear/Nose/Throat:	ear pain    hearing loss    ringing in ears    nose bleeds    sinus problems    tooth pain    hoarseness	NONE
Skin:	rashes    changing moles    change in skin color    other lesions    itchy skin	NONE
CV:	irregular heart beat    palpitations    chest pains    cramping in legs    feet always cold	NONE
Lungs:	cough    cough up blood    wheezing    night sweats    swollen ankles    shortness of breath	NONE
GI:	poor appetite    indigestion/heartburn    nausea    vomiting blood    abdominal pain/cramps constipation    change in bowel habits    rectal bleeding	NONE
GU/GYN:	urinate at night more than once    blood in urine    burning or pain when urinating problems passing urine    problems controlling urine	NONE
Neuro:	leg or arm weakness    balance problems    dizziness    fainting spells    speech problems	NONE
MS:	joint pains    joint swelling    loss of strength    back pain	NONE
Hemo:	abnormal bruising    abnormal bleeding	NONE
Endocrine:	constant thirst    most always cold    too warm most times    very sluggish or tired	NONE

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MD/PA: \_\_\_\_\_ Date: \_\_\_\_\_