



MEDICAL HISTORY

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Name:

Today's Date:

Date of Birth:

Surgical History		Vaccines Date	
		Tdap	Shingrex
		Pneumovax -13	Flu Shot- most recent
	most recent Colonoscopy	Pneumovax-23	

Medical History			
<input type="checkbox"/> Abdominal Pain – Chronic	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Allergies/Hayfever	<input type="checkbox"/> Gout	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Measles <input type="checkbox"/> Rubella
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Ankles – Swollen	<input type="checkbox"/> Headaches – Frequent	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Appetite – Loss of	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sexual/Menstrual Dysfunction	<input type="checkbox"/> Herpes
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Other:
<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Hernia	<input type="checkbox"/> Stools – Bloody or Tarry	FEMALES – Please Complete
<input type="checkbox"/> Back Pain – Recurrent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bone Fracture/Joint Injury	<input type="checkbox"/> Indigestion or Heartburn	<input type="checkbox"/> Swallowing Difficulty	Planning Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bowel Habits – Change in	<input type="checkbox"/> Infections – Frequent	<input type="checkbox"/> Sleep Apnea	Menstrual Flow:
<input type="checkbox"/> Bronchitis/Chronic Cough	<input type="checkbox"/> Jaundice/Hepatitis	<input type="checkbox"/> Throat – Sore – Frequent	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain / Cramps
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Thyroid Disease	Days of flow Length of Cycle
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Tremor / Hands Shaking	Date – 1 st day of last period:
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Leg Pain - Walking	<input type="checkbox"/> Ulcers - Peptic	<input type="checkbox"/> Pain/Bleeding during or after sex.
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Urethral Discharge	Number of:
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Urination- <input type="checkbox"/> Overnight>Than Twice	Pregnancies Abortions
<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Moodiness - Excessive	<input type="checkbox"/> Decrease in Force/Flow	Miscarriages Live Births
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control	Birth Control Method
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Nausea/Vomiting – Persistent	<input type="checkbox"/> Urine – Blood in	B.C. Pill (Name):
<input type="checkbox"/> Ear Infections – Frequent	<input type="checkbox"/> Nervousness <input type="checkbox"/> Depression	<input type="checkbox"/> Varicose Veins/Phlebitis	<input type="checkbox"/> Flushing/Menopause
<input type="checkbox"/> Ear – Ringing In	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Venereal Disease	Date of Last PAP Test
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Numbness/Tingling Sensations	<input type="checkbox"/> Vision - Failing	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> Fatigue - Chronic	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Weight Loss	Date of Last Mammogram
<input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet	<input type="checkbox"/> Phobias		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal



Family History											
		Father's Parents		Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder						Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:					
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:					
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:					

Habits			
<input type="checkbox"/>	Alcohol: Type Amount	<input type="checkbox"/>	Diet: Salt Intake Fat Intake Other
<input type="checkbox"/>	Coffee: Cups Daily Other Caffeine	<input type="checkbox"/>	Exercise Routine:
<input type="checkbox"/>		<input type="checkbox"/>	Sleep: Difficulty Falling Asleep Continuity Disturbances Early Morning Awakening Daytime Drowsiness Other:
<input type="checkbox"/>		<input type="checkbox"/>	Smoke: Packs Daily How long? Interested in stopping?

Comments:
