NAME _____ AGE _____ DATE _____

OCCUPATION _____ BIRTH PLACE _____

PRESENT PROBLEM - LIST DATES - PLEASE EXPLAIN IN DETAIL:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL HISTORY

ILLNESS: Have you ever had:

Please Encircle all answers

Measles _____ no yes
Mumps _____ no yes
Chicken Pox _____ no yes
Diphtheria _____ no yes
Pneumonia _____ no yes
Pleurisy _____ no yes
Rheumatic Fever _____ no yes
Arthritis _____ no yes
Neuritis _____ no yes
Bursitis _____ no yes
Heart Attack _____ no yes
Anemia _____ no yes
Jaundice _____ no yes
Tuberculosis _____ no yes
Diabetes _____ no yes
Cancer _____ no yes
High Blood Pressure _____ no yes
Other _____ no yes

SURGICAL: Have you had: Date

Appendectomy _____ no yes _____
Hernia _____ no yes _____
Tonsillectomy _____ no yes _____
Blood Transfusion _____ no yes
Bleeding Problem _____ no yes

OTHER SURGERIES Date

1. _____ _____
2. _____ _____
3. _____ _____

WEIGHT

Now _____
1 Year Ago _____
Maximum _____

ALLERGIES: -- Are you Allergic to

Penicillin _____ no yes
Sulfa _____ no yes
Other Antibiotics _____ no yes
Merthiolate – Mercurachrome _____ no yes
Any Other Drug _____ no yes
Adhesive Tape _____ no yes

LIST ALL MEDICINES REGULARLY TAKEN OR TAKEN IN THE LAST 6 MONTHS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALCOHOLIC BEVERAGES: NEVER [ ] RARELY [ ] MODERATELY [ ] DAILY [ ]

TOBACCO: DO YOU SMOKE YES [ ] NO [ ] HAVE YOU EVER SMOKED YES [ ] NO [ ]

WOMEN ONLY

MENSTRUAL HISTORY:

Age at onset _____

Date of last period _____

PROBLEMS WITH PERIODS OR PREGNANCY

_____

_____

FAMILY HISTORY		Age	If Living Health	Age at death	If Deceased Cause	Has any relative ever had	no or yes	Who
Father						Cancer	no or yes	
Mother						Tuberculosis	no or yes	
Brother's & Sister's	1.					Diabetes	no or yes	
	2.					Heart Trouble	no or yes	
	3.					High Blood Pressure	no or yes	
	4.					Stroke	no or yes	
	5.							
Husband or Wife								
Children	1.							
	2.							
	3.							
	4.							
	5.							

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

REVIEW OF SYSTEMS – Do you now have or have you ever had

EENT:

Any eye diseases, injury, impaired sight _____ no yes
Glasses _____ no yes
Any ear disease, injury, impaired hearing _____ no yes
Hearing Aid _____ no yes
Any trouble with nose, sinuses, mouth, throat _____ no yes
Dentures _____ no yes

CNS:

Loss of consciousness _____ no yes
Convulsions _____ no yes
Paralysis _____ no yes
Frequent or severe headaches _____ no yes

ENDOCRINE:

Enlarged glands _____ no yes
Enlarge thyroid or goiter _____ no yes
Skin Disease _____ no yes
Breast Problems _____ no yes

CARDIO-PULMONARY:

Chronic or frequent cough _____ no yes
Chest pain or angina pectoris _____ no yes
Spitting up blood _____ no yes
Heart attack _____ no yes
Shortness of breath _____ no yes
Palpitation or fluttering heart _____ no yes
Swelling of feet or ankles _____ no yes
Varicose veins _____ no yes

GASTRO-INTESTINAL:

Stomach trouble or ulcers _____ no yes
Indigestion _____ no yes
Liver or gall bladder disease _____ no yes
Colitis or other bowel disease _____ no yes
Hemorrhoids or rectal bleeding _____ no yes
Constipation _____ no yes
Chronic Diarrhea _____ no yes
Has there been any recent change in:
Your appetite or eating habit _____ no yes
Your bowel action or stool _____ no yes

GENITO-URINARY

Prostate enlargement _____ no yes
Kidney disease or stones _____ no yes
Bladder disease _____ no yes
Albumin, sugar, pus etc. in urine_____ no yes
Difficulty in urinating _____ no yes
Arise at night to urinate _____ no yes

NEUROMUSCULAR

Stroke _____ no yes
Weakness in arm or leg _____ no yes
Muscle spasm or cramps in legs with walking _____ no yes

IF ANSWERS TO ANY QUESTIONS ARE "YES" PLEASE EXPLAIN IN DETAIL:

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