

MEDICAL HISTORY

- Please fill out all of the following questions to the best of your ability
Please write N/A if a question is not applicable to you

Patient Name: Date of Birth: Age: Date:
Height: Weight: Occupation/Job title:

REASON FOR YOUR VISIT:

Please explain the reason for your visit today:

Three horizontal lines for writing the reason for the visit.

Do you or have you had any of the following? Check all that apply

NERVOUS SYSTEM Epilepsy Seizures Stroke Mental Illness

HEART Heart Attacks Hypertension Irregular Heart Beats

LUNGS/AIRWAY Sleep Apnea Emphysema Shortness of Breath Smoke

LIVER Cirrhosis Hepatitis Other Liver Disease

GI/GU Hernia Kidney Disease Ulcers

ENDOCRINE Diabetes Thyroid Disorders

BLOOD Bleeding Disorders Blood Transfusions

MUSCULOSKELETAL Metal Implants Arthritis Pierced/Cut skin

BREAST Rashes Under or Between Breast Present Bra Size
Date/Result Last Mammogram

ANESTHESIA Adverse Reactions (explain)
Family History(explain)

PREVIOUS SURGERIES (include dates)

PREVIOUS ACCIDENTS/INJURIES (include dates)

MEDICATIONS (list all medication currently taking include dosage)

DIETARY SUPPLEMENTS

ALLERGIES(list medication allergies,including what happens when you take them)

FAMILY HISTORY Cancer Diabetes Heart Attack Stroke Bleeding Problems
(if checked explain)