

MEDICAL HISTORY All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

- GENERAL**
- Chills
 - Depression/Nervousness
 - Dizziness/Fainting
 - Fever
 - Forgetfulness
 - Headache
 - Loss of sleep
 - Loss of weight
 - Numbness
 - Sweats

- GASTROINTESTINAL**
- Appetite poor
 - Bloating
 - Bowel changes
 - Constipation
 - Diarrhea
 - Excessive thirst
 - Gas
 - Hemorrhoids
 - Indigestion
 - Nausea
 - Rectal bleeding
 - Stomach pain
 - Vomiting
 - Vomiting blood

- EYE, EAR, NOSE, THROAT**
- Bleeding gums
 - Blurred vision
 - Crossed eyes
 - Difficulty swallowing
 - Double vision
 - Earache/Ear discharge
 - Hay fever
 - Hoarseness
 - Loss of hearing
 - Nosebleeds
 - Persistent cough
 - Ringing in ears
 - Sinus problems
 - Vision - Flashes/Halos

- MUSCLE/JOINT/BONE**
Pain, weakness, numbness in:
- Arms
 - Back
 - Feet
 - Hands
 - Hips
 - Legs
 - Neck
 - Shoulders

- CARDIOVASCULAR**
- Chest pain
 - High/Low blood pressure
 - Irregular/Rapid heart beat
 - Poor circulation
 - Swelling of ankles
 - Varicose veins

- SKIN**
- Bruise easily
 - Hives
 - Itching/Rash
 - Change in moles
 - Scars
 - Sore that won't heal

- GENITO-URINARY**
- Blood in urine
 - Frequent urination
 - Lack of bladder control
 - Painful urination

Check (✓) conditions you have or have had in the past.

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency

- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol

- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

HEALTH HABITS

Check (✓) which you use and how much:

Check (✓) if your work exposes you to:

Caffeine _____

Stress

Street Drugs _____

Heavy Lifting

Tobacco _____

Hazardous Substances

Other _____

Other _____

Your occupation _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date