

MEDICAL HISTORY AND EXAM FORM

DATE: _____

NAME (FIRST, MIDDLE, LAST)	AGE	DATE OF BIRTH
STREET ADDRESS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
(CITY, STATE & ZIP)		HOME PHONE
OCCUPATION		WORK PHONE
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
IF MARRIED, SPOUSE'S NAME		
CHILDREN'S NAME (S) AND AGE (S)		
ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE AND TYPE OF REACTION):		

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE CIRCLE IF **YOU** HAVE HAD PROBLEMS WITH OR ARE PRESENTLY COMPLAINING OF ANY OF THE FOLLOWING

<input type="checkbox"/> 1. HIGH BLOOD PRESSURE <input type="checkbox"/> 2. DIABETES <input type="checkbox"/> 3. CANCER <input type="checkbox"/> 4. HEART DISEASE <input type="checkbox"/> 5. CHEST PAIN / CHEST TIGHTNESS <input type="checkbox"/> 6. SHORTNESS OF BREATH <input type="checkbox"/> 7. SWOLLEN ANKLES <input type="checkbox"/> 8. PALPITATIONS <input type="checkbox"/> 9. LIGHTHEADEDNESS <input type="checkbox"/> 10. FREQUENT URINATION <input type="checkbox"/> 11. RHEUMATIC FEVER <input type="checkbox"/> 12. ASTHMA <input type="checkbox"/> 13. BREAST MASSES / DISCHARGE <input type="checkbox"/> 14. DEAFNESS <input type="checkbox"/> 15. MUSCLE PAIN <input type="checkbox"/> 16. URINARY INFECTIONS <input type="checkbox"/> 17. NECK STIFFNESS <input type="checkbox"/> 18. BRONCHITIS	<input type="checkbox"/> 19. PNEUMONIA <input type="checkbox"/> 20. PERSISTENT COUGH <input type="checkbox"/> 21. T.B. <input type="checkbox"/> 22. HAY FEVER <input type="checkbox"/> 23. ABDOMINAL DISCOMFORT <input type="checkbox"/> 24. INDIGESTION <input type="checkbox"/> 25. NAUSEA <input type="checkbox"/> 26. VOMITING <input type="checkbox"/> 27. CONSTIPATION <input type="checkbox"/> 28. DIARRHEA <input type="checkbox"/> 29. BLOOD IN STOOL <input type="checkbox"/> 30. ULCERS <input type="checkbox"/> 31. URINATE AT NIGHT <input type="checkbox"/> 32. WEAKNESS <input type="checkbox"/> 33. URINARY INCONTINENCE <input type="checkbox"/> 34. POST NASAL DRIP <input type="checkbox"/> 35. DIFFICULTY SWALLOWING <input type="checkbox"/> 36. CHANGE IN BOWEL HABITS	<input type="checkbox"/> 37. UNEXPLAINED WEIGHT GAIN / LOSS <input type="checkbox"/> 38. HEMORRHOIDS <input type="checkbox"/> 39. GALL BLADDER DISEASE <input type="checkbox"/> 40. COLITIS <input type="checkbox"/> 41. HEPATITIS OR JAUNDICE <input type="checkbox"/> 42. THYROID DISEASE <input type="checkbox"/> 43. HEAD OR NECK RADIATION <input type="checkbox"/> 44. HEADACHE <input type="checkbox"/> 45. KIDNEY DISEASES <input type="checkbox"/> 46. KIDNEY STONES <input type="checkbox"/> 47. DIFFICULTY URINATING <input type="checkbox"/> 48. PAINFUL BOWEL MOVEMENT <input type="checkbox"/> 49. BLOOD IN URINE <input type="checkbox"/> 50. NASAL DISCHARGE <input type="checkbox"/> 51. DEFORMITIES <input type="checkbox"/> 52. ARTHRITIS <input type="checkbox"/> 53. LOW BACK PROBLEMS	<input type="checkbox"/> 54. SKIN DISEASES <input type="checkbox"/> 55. BLOOD DISORDERS <input type="checkbox"/> 56. VENEREAL DISEASES <input type="checkbox"/> 57. ANXIETY <input type="checkbox"/> 58. DEPRESSION <input type="checkbox"/> 59. ANEMIA <input type="checkbox"/> 60. ALCOHOL ABUSE <input type="checkbox"/> 61. DRUG ABUSE <input type="checkbox"/> 62. GOUT <input type="checkbox"/> 63. COUGHING BLOOD <input type="checkbox"/> 64. CHANGE IN APPETITE <input type="checkbox"/> 65. INSOMNIA <input type="checkbox"/> 66. RINGING IN EARS <input type="checkbox"/> 67. TINGLING/NUMBNESS <input type="checkbox"/> 68. SORENESS OF THROAT <input type="checkbox"/> 69. OTHER (PLEASE SPECIFY):
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PLEASE LIST AND SUPPLY THE DATES OF:

OPERATIONS:

HOSPITALIZATIONS OTHER THAN FOR SURGERY:

