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Medical History Form

Patient Name: _____ Date of Birth: _____

Reason for visit: (chief complaint): _____

Past History:

Major Illnesses:

- High Blood Pressure, Diabetes, High Cholesterol, Heart Disease, Cancer, Seizures / Epilepsy, Sleep Apnea, Headaches, Stroke, Arthritis, Thyroid Disease, Lung disease, Blood Disorder, Kidney Disease, Mental Illness, Ulcers, Other Illness

Hospitalization/Surgeries:

Review of Systems:

Please indicate any other problem by checking YES or NO:

YES NO

- NEUROLOGY: Problems other than chief complaint, explain:
Fatigue, fever, weight loss/gain (If yes, explain):
Sleep Problems: insomnia, restlessness, early morning awakening, snoring, fragmented sleep (If yes, explain):
Eyes, Visual Problems
Ears, Nose, Mouth and Throat: ringing ears, hearing loss, congestion, pain
Muscle or Bone Problems
Skin/Breast: rashes, itching, hair growth/loss
Mental/Nervous Disorders: anxiety, depression polar disorders
Urinary Systems: incontinence, frequency, urgency, pain
Blood, Lymph
Stomach, Intestines: changes in bowel habits, decreased appetite
Cardiovascular: chest pain, murmurs, fainting
Respiratory: pain, shortness of breath, cough, wheezing

Current Medications and Dosage:

Blank lines for listing current medications and dosages.

Medication Allergies: None

Blank lines for listing medication allergies.

Social History:

Single Divorced Number of children:
Married Widowed Ages:

Occupation: (if retired, please list date and occupation retired from)

Do you use (check if YES):

- Tobacco products Packs per day:
Alcohol Drinks per day: Drinks per week:
Caffeine Use per day: Use per week:
Other substance: (marijuana, cocaine, opiates, amphetamines, other) If yes, when last used:

Family History (Please check Y or N for each parent):

Mother Father

Y N Y N

- Stroke:
Seizures/Epilepsy:
Headaches:
High Blood Pressure:
Heart Disease:
Cancer:
Diabetes:
High Cholesterol:
Other Illness:

Please initial and date:

Initial: _____ Date: _____