Name: ________________________________

Medical History

Date:____________Acct #_____________

Please list in the spaces provided. Information is confidential and will not be released without your permission.											
Operations and Dates (Example Tonsillectomy 1985)			**Do you now have or had any problems related to the following systems?**								
			Respiratory	**(Circle one)**		**Endocrine**	**(Circle one)**		**Musculoskeletal**	**(Circle one)**	
			Asthma	Yes	No	Cold Intolerance	Yes	No	Arthralgia	Yes	No
			Cough	Yes	No	Heat Intolerance	Yes	No	Back Pain	Yes	No
			Short Breath	Yes	No	Polydisia	Yes	No	Fracture	Yes	No
Family History of Eye Disease (Ex: Relative / Disease)			SOB on exertion	Yes	No	Polyphagia	Yes	No	Joint Stiffness	Yes	No
			Coughing Up Blood	Yes	No	Polyuria	Yes	No	Joint Swelling	Yes	No
			Wheezing	Yes	No	Other			Muscle Cramping	Yes	No
			Other			**Neurological**	**(Circle one)**		Muscle Weakness	Yes	No
			Cardiovascular	**(Circle one)**		Balance Disorder	Yes	No	Other		
Blindness	Yes	No	Arrythmia	Yes	No	Dizziness	Yes	No	**Hematological**	**(Circle one)**	
For Females - Is it possible you are pregnant?			Calf Pain	Yes	No	Focal Weakness	Yes	No	Bleeding	Yes	No
Smoking History			Chest Pain	Yes	No	Gaid Disorder	Yes	No	Brusing	Yes	No
Never smoked / Past smoker / Present smoker			Palpitations	Yes	No	Headaches	Yes	No	Lymph Node Swelling	Yes	No
How much?			leg swelling	Yes	No	Memory Issues	Yes	No	Tender Nodes	Yes	No
How long?			Rapid Heart	Yes	No	Numbness	Yes	No	Headaches	Yes	No
Alcohol Use			Other			Other			Memory Issues	Yes	No
Never to rarely / Light / Moderate / Heavy			**Gastrointestinal**	**(Circle one)**		**Psychiatric**			Numbness	Yes	No
How much?			Abdominal Pain	Yes	No	Depression	Yes	No	Other		
How long?			Rectal blood/black stools	Yes	No	Emotional Changes	Yes	No	**Immunological**	**(Circle one)**	
			Constipation	Yes	No	Euphoria	Yes	No	Environment Allergy	Yes	No
Do you now have or had any of these problems?			Loss of Appetite	Yes	No	Frequent Nightmare	Yes	No	Food Allergy	Yes	No
Constitutional Symptoms	**(Circle one)**		Diarrhea	Yes	No	Hallucinations	Yes	No	Seasonal Allergy	Yes	No
Fatigue	Yes	No	Difficulty Swallowing	Yes	No	Insomnia	Yes	No	Other		
Fever	Yes	No	Food intolerance	Yes	No	Irritability	Yes	No			
Night Sweats	Yes	No	Heartburn	Yes	No	Nervousness	Yes	No	Use for Addition Information:		
Weakness	Yes	No	Increased Appetite	Yes	No	Stress	Yes	No			
Weight Gain	Yes	No	Jaundice	Yes	No	Other					
Weight Loss	Yes	No	Nausea	Yes	No	**Skin**	**(Circle one)**				
Other			Vomitting	Yes	No	Abnormal Hair Distribution	Yes	No			
Ear/Nose/Throat	**(Circle one)**		Other			Dry Skin	Yes	No			
Exophthalmolos	Yes	No	**Genitourinary/gyn**	**(Circle one)**		Hives	Yes	No			
Hearing loss	Yes	No	Dysuria	Yes	No	Itching	Yes	No			
Hoarseness	Yes	No	Genital Lesions	Yes	No	Nail Cahnges	Yes	No			
Lump in Neck	Yes	No	Blood in Urine	Yes	No	Rash	Yes	No			
Nasal Congestion	Yes	No	Irregular Periods	Yes	No	Skin Changes	Yes	No			
Sinus Problems	Yes	No	Urethral Discharge	Yes	No	Skin Lesions	Yes	No			
Sore Throat	Yes	No	Urgency	Yes	No	Nodules	Yes	No			
Tinnitus	Yes	No	Other			Sores	Yes	No			
Vertigo	Yes	No				Ulers	Yes	No			
Other						Other					

Name: ___________________________________ **MEDICAL HISTORY** Date:_____________Acct #______________

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Current Medications (Ex: glyburide 5mg once a day)

Medication Name	Dose	Frequency	LIST MEDICAL ALLERGIES BELOW