

MEDICAL AND SURGICAL HISTORY

Please help us serve you better by completing your medical history before you see the Doctor.
Your medical record is strictly confidential.

Name : _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Language: (please circle) English Spanish Other: _____

Race: (please circle) White/Caucasian American Indian Asian Black Native Hawaiian Unknown

Ethnicity: (please circle) Hispanic Origin Non-Hispanic Origin Unknown

Reason you are seeing the doctor today: _____

How long have you had this problem: _____

How many times have you been treated for this problem in the past year? _____

What medications or tests have you received for this problem in the past? _____

Medical Information

Allergic to any medications? No _____ Yes _____ If yes, please indicate: _____

List medications you are taking now: _____

Do you take aspirin? No _____ Yes _____ How often? _____

List any food or environmental allergies you may have: _____

List all previous medical problems: _____

List all previous surgeries: _____

Social History

Do you smoke tobacco? Never _____ Past _____ Present _____ Heavy Smoker _____ Light Smoker _____

Average packs per day _____ Approx start date? _____ Approx quit date? _____

Do you use chewing tobacco or smoke cigars? No _____ Yes _____ Amount per day? _____

Do you drink alcohol? _____ Amount per day? _____

Family History

Please list any illnesses which run in your family(list specific family members) including any bleeding Disorders or bad reactions to anesthesia during surgeries:

GENERAL YES

1. Fever
2. Chills
3. Weight loss
4. Night sweats
5. Other _____

EARS YES

1. Hearing loss - gradual
2. Hearing loss - sudden
3. Pain
4. Ringing
5. Dizziness or vertigo
6. Frequent infections
7. Other _____

NOSE YES

1. Nose bleeds
2. Injury
3. Congestion
4. Runny nose
5. Mouth breather
6. Other _____

THROAT YES

1. Frequent sore throats
2. Difficulty swallowing
3. Hoarseness
4. Foreign body
5. Thyroid problems
6. Swollen tonsils
7. Other _____

EYES YES

1. Cataracts
2. Glaucoma
3. Distorted vision
4. Other _____

HEART YES

1. High blood pressure
2. Chest pain
3. Irregular heart beat
4. Previous heart attack
5. Other _____

LUNGS YES

1. Bronchitis/chronic cough
2. Asthma/wheezing
3. Congestion
4. Other _____

ALLERGY/ IMMUNE YES

1. Seasonal allergies
2. Itchy eyes
3. Runny Nose
4. Allergy testing in past
5. HIV or AIDS

GASTROINTESTINAL YES

1. Indigestion or Heartburn
2. Ulcers
3. Diarrhea
4. Diverticulitis
5. Gall bladder trouble
6. Nausea & vomiting
7. Other _____

URINARY TRACT YES

1. Kidney problems
2. Painful urination
3. Bloody urination
4. Prostate problems (men)
5. Other _____

MUSCULOSKELETAL YES

1. Back pain
2. Weakness of limbs
3. Arthritis
4. Other _____

NEURO/PYSCH YES

1. Numbness
2. Migraine headaches
3. Seizures
4. Convulsions
5. Stroke
6. Depression
7. Other _____

ENDOCRINE YES

1. Thyroid disorders
2. Diabetes
3. Menopause (women)
4. Hormonal replacement
5. Pregnant (women)

BLOOD DISORDERS YES

1. Low blood counts
2. Free bleeding
3. Blood clots
4. Blood disorders
5. Hepatitis
6. Other _____