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_____