# Medical History

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form is for your medical history.

Please Mark YES or NO

**General Medical History:**

**Yes No**

Diabetes 

How many yrs? \_\_\_\_\_\_

Insulin Use? 

Hypertension 

How many years? \_\_\_\_\_\_

Arthritis 

Cancer 

Migraine 

Thyroid Problem 

Stroke 

Lung Disease/Asthma 

Heart Attack 

HIV/ AIDS 

Tuberculosis 

Kidney Disease 

Any Previous Surgery? 

If yes, please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No**

Other medical problems? 

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:**

Does anyone in your family have? **Yes No**

Diabetes 

Hypertension 

Glaucoma 

Macular Degeneration 

Cataracts 

**Social History:**

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No**

Do you smoke? 

How many packs per day? \_\_\_\_\_\_

Do you drink alcohol? 

How many drinks per week? \_\_\_\_\_\_

Are you allergic to any

medications? 

List the medications to which you are allergic and the allergic reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

Are you suffering from any of these?

**Yes No**

## Constitutional:

Weight loss 

Weight Gain 

Fatigue 

Fever 

## Cardiovascular:

Chest Pain 

Swelling of feet 

## Respiratory:

Shortness of Breath 

Wheezing 

Cough 

## Neurological:

Headache 

Convulsions 

Weakness of Extremities 

Numbness of Extremities 

## Ear, Nose, Mouth and Throat:

Decreased Hearing 

Hearing aid use 

**Yes No**

Sinsusitis 

Nasal congestion 

Sore throat 

## Blood and Lymphatics:

Easy bruising 

Swollen lymph nodes 

## Skin:

Skin rash 

Skin moles 

## Gastrointestinal:

Heartburn 

Stomach pain 

## Muscles and Bones:

Arthritis 

Weakness 

Easily broken bones 

## Psychiatric:

Depression 

Nervousness 