MEDICAL HISTORY

Patient Name: _____ Age _____ Date of Print: _____

Please Circle Any That Apply.

IDENTIFY THE MAIN REASON FOR THE VISIT

EXAMPLES: **A**bnormal Labs, Abnormal X-Ray, **C**heck-Up, **D**rug Monitoring/Therapeutic Monitoring, **F**ollow-Up of Previously Identified Problems, **G**eneral Follow-Up,

Digestive Symptoms – (**A**bdominal Pain, Acidic Stomach Altered Bowl Habits, **B**loating/Gas, **C**onstipation, **D**ark Urine, Diarrhea, Difficulty Swallowing, **F**eeding Difficulties, Food Intolerance, **H**eartburn, "**I**ndigestion", Irregular Bowl Movements, **L**ack of Appetite, **N**ausea/ Vomiting, Need for Laxatives, **R**ectal Bleeding, **W**eight Loss/Weight Gain)

Non-Digestive Symptoms – (Back Pain, Chest Pain, Extremity and Joint Pain, Headache, Influenza, Respiratory Symptoms, Other)

Comments:

ANY ALLERGIES OR SIDE-EFFECTS OF MEDICATIONS OR ANESTHESIA? Yes / No

Latex Allergy?: Yes / No **Aspirin Use**: Yes / No

PAST MEDICAL HISTORY: - Acid Reflux, Asthma, **B**leeding Problems, Blood Transfusions, **C**ancer, Convulsions, Crohns/ Colitis, **D**epression, Diverticulitis, Diabetes Mellitus, **E**pilepsy, **G**out, **H**igh Blood Pressure, Heart Attack, Heart Disease, Hemorrhoids, Hepatitis, **I**BS, **J**aundice, **K**idney Stones, Kidney/Bladder Infections, **L**iver Disease, Nervous Breakdown-Requiring Formal Psychiatric Evaluation, **P**eptic Ulcer Disease, **S**eizure Disorder, Sleep Disorder/ Apnea, Stroke, **T**hyroid disease, **T**B,

Comments:

PAST SURGICAL HISTORY: – Abdominal, Appendix, **B**reast, **C**ancer, Cosmetic, **F**oot, **G**allbladder, **H**eart, Hemorrhoids, Hernia, Hysterectomy, **P**olyp Removal, **R**emoval of Ovaries, **S**kin, **T**onsillectomy, **U**lcer, **V**aricose Veins, **GI: C**apsule Endoscopy, Colonoscopy, **E**ndoscopy, Endoscopic Ultrasound, ERCP, **L**iver Biopsy, Other:

FAMILY HISTORY: - Cancer, Diabetes, Heart Disease, High Blood Pressure, Ulcer

SOCIAL HISTORY: – Single, Married, Widowed, Divorced, Number of Children: ____ Smoking History: Y. N. # of Yrs? ____Per Day? ____ Alcohol Consumption: Y. N. ___day, wk, mo # of Yrs?____ Recreational Drug Use: Y.N. Coffee/Tea: Y. N ___ day, wk, mo, yr

General	**Eyes**	**Nose**	**Throat**
Tire Easily/Weakness	Trouble Seeing	Loss of Smell	Postnasal Drainage
Night Sweats	Eye Pain	Frequent Colds	Soreness
Persistent Fever	Inflamed Eyes	Obstruction	Hoarseness
Skin	Double Vision	Excess Discharge	**Breasts**
Eruptions (Rash)	**Ears**	Nosebleeds	Lumps
Change in Color	Loss of Hearing	**Mouth**	Discharge
Change in Hair	Ringing in the Ears	Sore Gums	
Change in Nails	Discharge	Soreness of Tongue	
		Dental Problems	

Please Circle Any That Apply

Cardio Respiratory Systems
Cough Persisting
Sputum (Phlegm)
Bloody Sputum
Wheezing
Chest Pain or Discomfort
Pain on Breathing
Shortness of Breath
Difficulty Breathing While Lying Down
Swelling of Ankles
Bluish Fingers or Lips
High Blood Pressure
Palpitations

Gentourinary System
Increase in Frequency of Urination Day/Night
Feel Need to Urinate Without Much Urine
Unable to Hold Urine
Pain or Burning
Blood in Urine
Impotence
Lack of Sex Drive
Pain with Intercourse

Endocrine
Thyroid Trouble
Adrenal Trouble
Cortisone Treatment
Diabetes

Locomotor
Muscle Cramps
Muscle Weakness
Pain in Joints
Swollen Joints
Stiffness
Deformity of Joints

Nervous System
Anxiety
Headaches
Dizziness
Fainting
Convulsions or Seizures
Nervousness
Sleeplessness
Depression
Change in Sensation
Memory Loss
Poor Coordination
Weakness or Paralysis

Obtained by: _____ Reviewed by Physician: _____ **Date of Appointment**_____

ALL CURRENT MEDICATIONS AND SUPPLEMENTS

Patient Name: _____ Primary Physician: _____ Date:_____

Allergies: _____ Pharmacy:_____ Ph: _____

Medications / Supplements.	Dosage	Frequency	Start Date	Comments