Medical History Form

Patient name: _____ Date of birth: _____

What are you here for? _____

Who referred you? _____ Name of primary care physician _____

Are you allergic to any medications? YES NO If yes, please list:

_____ _____ _____ _____ _____

List any medications and dosages you are taking (including prescriptions, over-the-counter, herbals, vitamins and creams):

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

MEDICAL HISTORY.
Please check if you have ever had any of the following diseases or conditions?

Cardiovascular
- High blood pressure [ ]
- Pacemaker [ ]
- Defibrillator [ ]
- Irregular heartbeat [ ]
- Heart attack [ ]
- Heart murmur [ ]
- Blood clots [ ]
- Stent [ ]
- Coronary artery disease [ ]
- Stroke [ ]
- Other _____ [ ]

Respiratory
- Emphysema/COPD [ ]
- Asthma [ ]
- Pneumonia [ ]
- Other _____ [ ]

Gastrointestinal/Genitourinary
- Reflux/GERD [ ]
- Kidney stones [ ]
- Kidney failure [ ]
- Bladder dysfunction [ ]
- Other _____ [ ]

Endocrine
- Diabetes Type I [ ] Type II [ ]
- Thyroid disease [ ]
- Other _____ [ ]

Head/Eyes/Ear/Nose/Throat
- Migraines [ ]
- Cataracts [ ]
- Glaucoma [ ]
- Other _____ [ ]

Infections
- MRSA [ ]
- HIV/AIDS [ ]
- Tuberculosis [ ]
- Hepatitis Type _____ [ ]
- Other _____ [ ]

Cancers
- Breast [ ]
- Ovarian [ ]
- Lung [ ]
- Colon [ ]
- Prostate [ ]
- Bladder [ ]
- Other _____ [ ]

Psychiatric/Neurologic
- Epilepsy/seizure disorder [ ]
- Alzheimer's [ ]
- Parkinson's [ ]
- Other dementia [ ]
- Depression [ ]
- Bipolar disorder [ ]
- Other _____ [ ]

Musculoskeletal
- Rheumatoid arthritis [ ]
- Osteoarthritis [ ]
- Artificial joint(s) [ ]
- Fibromyalgia [ ]
- Other _____ [ ]

Skin
- Skin cancer [ ]
  - [ ] Basal cell carcinoma
  - [ ] Squamous cell carcinoma
  - [ ] Malignant melanoma
- Precancerous lesions (actinic keratosis) [ ]
- Abnormal (dysplastic) moles [ ]
- Blistering sunburn [ ]
- Family history of melanoma [ ]
- Other _____ [ ]
- Other _____ [ ]

SURGICAL HISTORY. Please list any surgeries or cosmetic procedures you have had:

_____

_____

_____

_____

REVIEW OF SYSTEMS.
Please check if you are currently experiencing any of the following symptoms?

Cardiovascular
- Chest pain [ ]
- Palpitations [ ]
- Other _____ [ ]

Respiratory
- Shortness of breath [ ]
- Cough [ ]
- Other _____ [ ]

Head/Eyes/Ear/Nose/Throat
- Change in vision [ ]
- Ringing in ears [ ]
- Sore throat [ ]
- Headache [ ]
- Other _____ [ ]

Gastrointestinal/Genitourinary
- Abdominal pain [ ]
- Nausea/vomiting/diarrhea [ ]
- Pain with urination [ ]
- Other _____ [ ]

Musculoskeletal
- Joint pain [ ]
- Muscle pain [ ]
- Muscle weakness [ ]
- Other _____ [ ]

Systemic
- Fever/chills/night sweats [ ]
- Unexplained weight loss [ ]
- Other _____ [ ]

Psychiatric/neurologic
- Depression [ ]
- Anxiety [ ]
- Numbness/tingling [ ]
- Other _____ [ ]

Current Weight: _____ lbs

Current Height: _____ ft _____ in

FAMILY HISTORY.

	Mother	Father	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Cancer	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____

SOCIAL HISTORY.

Do you drink alcohol? YES NO If YES, how many a week/month? _____ What type? _____

Do you smoke? YES NO If NO, have you ever been a smoker? YES NO

What is your occupation? _____

Are you SINGLE MARRIED DIVORCED WIDOW/WIDOWER ?

Are you a year-round Florida resident? YES NO If NO, where else do you live? _____

_____ _____

PATIENT SIGNATURE (or name of person completing this form) DATE