

I have reviewed both sides of this medical history form. Physician Signature: _____

(Nurse to Complete: Blood Pressure: _____ Temp: _____ Pulse: _____)

New or Updated Patient Medical History (17 years or older)

In order for you to receive high quality care, **please answer all questions.** (Update Required Every Year.)

Name: _____ Date of Birth: _____ Your Primary M.D. _____

Date Form Filled Out: _____ Date of Appt: _____ Your Age: _____ Your Height: _____ Your Weight: _____

Which Physician Outside Of Our Group Sent You to Our Office For This Consultation (Office Visit)?: _____
(Physician First and Last Name)

Briefly, why are you seeing our physician today? _____

HAVE YOU RECENTLY SEEN ANOTHER PHYSICIAN FOR THIS CURRENT ILLNESS? YES NO

REVIEW OF SYSTEMS

INDICATE BELOW ANY SYMPTOMS **YOU ARE CURRENTLY HAVING:**

1. GENERAL:	YES	NO	6. ALLERGIC:	YES	NO
A. Fatigue	_____	_____	A. (circle)		
B. Weight Loss	_____	_____	Itchy eyes, ears,		
C. Fevers	_____	_____	nose, palate	_____	_____
D. Chills	_____	_____	B. Watery Eyes	_____	_____
E. Nausea	_____	_____	C. Scratchy Throat	_____	_____
F. Headaches	_____	_____	D. Sneezing Excessively	_____	_____
2. SKIN:			7. MOUTH:		
A. Lesions	_____	_____	A. Lesions	_____	_____
3. EYES:			B. Loss of Taste	_____	_____
A. Double Vision	_____	_____	8. THROAT:		
B. Blurred Vision	_____	_____	A. Pain	_____	_____
C. Loss of Vision	_____	_____	B. Hoarseness	_____	_____
4. EARS:			C. Cough	_____	_____
A. Hearing Loss	_____	_____	D. Difficulty Swallowing	_____	_____
B. Family History	_____	_____	E. Indigestion, Heartburn	_____	_____
C. Exposure-Loud Noises	_____	_____	9. NECK:		
D. Drainage	_____	_____	A. Pain and/or Lumps	_____	_____
E. Pain	_____	_____	10. HEART AND CIRCULATION:		
F. Noise in Ears (Tinnitus)	_____	_____	A. Chest Pain	_____	_____
G. Dizziness	_____	_____	B. Irregular Heart Beat	_____	_____
H. Hearing Aids	_____	_____	C. Leg Swelling	_____	_____
5. NOSE:			11. LUNGS:		
A. Pain	_____	_____	A. Shortness of Breath	_____	_____
B. Discharge	_____	_____	B. Congestion	_____	_____
C. Post Nasal Drip	_____	_____	C. Wheezing	_____	_____
D. Deformity	_____	_____	D. Productive Cough	_____	_____
E. Congestion	_____	_____	12. NERVES:		
F. Decreased Smell	_____	_____	A. Numbness	_____	_____
G. Bleeding	_____	_____	B. Localized Weakness	_____	_____
H. Snoring	_____	_____	C. Paralysis	_____	_____
			13. STOMACH AND INTESTINES:		
			A. Nausea and/or Vomiting	_____	_____
			14. BLOOD SYSTEM:		
			A. Bleeding or Easy Bruising	_____	_____

CONTINUED ON BACK PAGE

Please Print Your Name on Top of Back Page

Patient Name: _____

PAST HISTORY

	Yes	No		Yes	No
History of Exposure to HIV	_____	_____	Problems with General Anesthesia	_____	_____
Positive test for HIV (AIDS Virus)	_____	_____	History of Allergy Evaluation	_____	_____
Previous Surgery	_____	_____	History of Allergy Treatment	_____	_____

If you have had surgery, list the surgery with approximate dates:

INDICATE BELOW ANY HISTORY OF DISEASES YOU HAVE HAD

Medical Illnesses:	Yes	No		Yes	No
Lung Disease	_____	_____	Hypertension (High Blood Pressure)	_____	_____
Asthma	_____	_____	Urinary Disease	_____	_____
Heart Disease	_____	_____	Pelvic Disease	_____	_____
Blood Vessel Disease	_____	_____	Prostate Disease	_____	_____
Glaucoma	_____	_____	Kidney Disease	_____	_____
Arthritis	_____	_____	Diabetes	_____	_____
Bleeding tendency	_____	_____	Hepatitis	_____	_____
Seizures	_____	_____			

List any other health conditions _____

ALLERGIES TO MEDICATION

FAMILY HISTORY

INDICATE BELOW THE DISEASE IN YOUR PARENTS, BROTHERS OR SISTERS

	Yes	No		Yes	No
Cancer	_____	_____	Hearing Loss	_____	_____
Heart Disease	_____	_____	Bleeding Abnormalities	_____	_____
Hypertension (High Blood Pressure)	_____	_____	Anesthesia Complications	_____	_____
Lung Disease	_____	_____	Allergies	_____	_____

List any other health conditions _____

SOCIAL HISTORY

Current or Previous Occupation: _____

	Yes	No	
Are you retired?	_____	_____	
Are you pregnant?	_____	_____	
Caffeine Use?	_____	_____	
Alcohol Use?	_____	_____	Amount _____ per week.
Recreational Drug Use:	_____	_____	
Tobacco Use?	_____	_____	

Year Quit _____ If smoking, type of tobacco _____ # _____ of packs per day for # _____ years.

The above information is correct.

Patient Signature: _____