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MEDICAL HISTORY

TODAY'S DATE _____

NAME _____ AGE _____ OCCUPATION _____

PRIMARY PHYSICIAN _____ REFERRED BY _____

REASON FOR OFFICE VISIT _____

CURRENT MEDICATIONS (Include dose, how long on medication and reason)

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

DO YOU TAKE ASPIRIN? ____ YES ____ NO IF YES, MOST RECENT DOSE _____

ALLERGIES (medications, foods, etc. Please describe reaction)

MEDICAL HISTORY—PLEASE LIST **ALL** MEDICAL PROBLEMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PAST SURGICAL HISTORY

<u>OPERATION</u>	<u>REASON/HOSPITAL</u>	<u>DATE/LOCATION</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

DO YOU SMOKE? ____YES ____ NO DID YOU SMOKE? ____YES ____NO
IF SO, HOW MANY PACKS PER DAY? _____ HOW LONG? ____ QUIT _____

ALCOHOL ____YES ____ NO IF YES, HOW MUCH AND HOW OFTEN? _____
BEER WINE HARD LIQUOR

FAMILY HISTORY (if alive, age and health; if deceased, age at death/cause)

MOTHER _____

FATHER _____

Any blood relatives with a history of prostate, bladder, kidney or other urologic disorders, cancer, or stones? _____

HAVE YOU HAD? (please circle the correct answer)

Bleeding Problems	YES	NO	Blood Transfusions	YES	NO
Steroid/prednisone	YES	NO	Anemia	YES	NO
Diabetes	YES	NO	Thyroid Problems	YES	NO
Strokes	YES	NO	Stomach Ulcers	YES	NO
Phlebitis	YES	NO	Constipation	YES	NO
Fevers	YES	NO	Hiatal Hernia	YES	NO
Glaucoma	YES	NO	Diarrhea	YES	NO
Hepatitis	YES	NO	TB (Tuberculosis)	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO
Heart Problems	YES	NO	Emphysema/Bronchitis	YES	NO
Heart Attack	YES	NO	Pneumonia	YES	NO
Chest Pain	YES	NO	Epilepsy/Seizures	YES	NO
Heart Failure	YES	NO	Rheumatic Fever	YES	NO
Ankle Swelling	YES	NO	Cancer	YES	NO
Most Recent EKG	YES	NO	Where _____		
Date:			Artificial joint	YES	NO
Heart Murmur	YES	NO	Parkinson's	YES	NO
Weight Loss	YES	NO	Mumps	YES	NO
If yes, how much? _____			Have you been told to take		
Over how long? _____			prophylactic antibiotics with		
Are you trying to lose? YES NO			dental work? YES NO		