

Past Medical History / Family Medical History

Yourself	Yes	No	When (yr)	Family	Yes	No	Relationship
Arthritis	_____	_____	_____	Arthritis	_____	_____	_____
Asthma	_____	_____	_____	Asthma	_____	_____	_____
Cancer	_____	_____	_____	Cancer	_____	_____	_____
Diabetes	_____	_____	_____	Diabetes	_____	_____	_____
Emotional/Mental	_____	_____	_____	Emotional/Mental	_____	_____	_____
Epilepsy	_____	_____	_____	Epilepsy	_____	_____	_____
Glaucoma	_____	_____	_____	Glaucoma	_____	_____	_____
Heart Disease	_____	_____	_____	Heart Disease	_____	_____	_____
High BP	_____	_____	_____	High BP	_____	_____	_____
Intestinal	_____	_____	_____	Intestinal	_____	_____	_____
Kidney Disease	_____	_____	_____	Kidney Disease	_____	_____	_____
Lung Disease	_____	_____	_____	Lung Disease	_____	_____	_____
Seizures	_____	_____	_____	Seizures	_____	_____	_____
Tuberculosis	_____	_____	_____	Tuberculosis	_____	_____	_____
Ulcers	_____	_____	_____	Ulcers	_____	_____	_____

Hospitalization, For: Illness _____

Surgery: _____

Other Major Medical _____

Medications: _____

Allergies: _____

Do you smoke? Yes _____ No _____ How Long? _____ Packs per Day? _____

Use Alcohol? Yes _____ No _____ How Much? _____

Any Past/Present Substance Abuse? Yes _____ No _____ How Long? _____

Any Past/Present STD? Yes _____ No _____ Received Treatment? _____

Review of Systems: Do you Have

Illness	Yes	No	Illness	Yes	No
Frequent Headaches	_____	_____	Frequent urination	_____	_____
Blurred/Double Vision	_____	_____	Burning	_____	_____
Hearing Disorder	_____	_____	Difficulty Control	_____	_____
Difficulty with Balance	_____	_____	Difficulty Starting	_____	_____
Hay Fever/Sinus Trouble	_____	_____	Blood or Pus in Urine	_____	_____
Difficulty Swallowing	_____	_____	Large Volumes of Urine	_____	_____
Hoarseness	_____	_____	Very Little Urine	_____	_____
Neck Swelling	_____	_____	Bladder infection	_____	_____
Chest Pain	_____	_____	Prostate Trouble	_____	_____
Heart Murmur	_____	_____	Sexual Problem	_____	_____
History of Rheumatic Fever	_____	_____	Swelling	_____	_____
Heart Failure	_____	_____	Varicose Veins	_____	_____
Open Heart Disease	_____	_____	Numbness	_____	_____
Shortness of Breath	_____	_____	Weakness	_____	_____
with exercise	_____	_____	Abnormal Clumsiness	_____	_____
lying down	_____	_____	Heartburn	_____	_____
while asleep	_____	_____	Indigestion	_____	_____
Cough	_____	_____	Nausea	_____	_____
Cough up Blood	_____	_____	Vomiting	_____	_____
Asthma	_____	_____	Blood in Stools	_____	_____
Emphysema	_____	_____	Black, Tarry Stools	_____	_____
Chronic Lung Disease	_____	_____	Hemorrhoids	_____	_____
Liver Disease	_____	_____	Weight Loss	_____	_____

Patient Signature _____

Date _____