

Patient Name:

DOB:

Patient Medical History Form (p. 1): **Please provide the following medical information to the best of your ability:**

Date:	Age:	List any ALLERGIES TO MEDICATIONS:
What are your concerns for today's visit?:		
Past Medical History:		
1) Please check the "Yes" or "No" box to indicate whether you have any of the following illnesses; for "Yes" answers, please explain		
	<u>Yes</u> <u>No</u>	
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	
Hypertension (high blood pressu	<input type="checkbox"/> <input type="checkbox"/>	
Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/>	
Heart Disease/cholesterol probs	<input type="checkbox"/> <input type="checkbox"/>	
Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/>	
Stomach or Intestinal Problems	<input type="checkbox"/> <input type="checkbox"/>	
Allergy problems/therapy	<input type="checkbox"/> <input type="checkbox"/>	
Kidney problems	<input type="checkbox"/> <input type="checkbox"/>	
Neurological Problems	<input type="checkbox"/> <input type="checkbox"/>	
Other Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/>	
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):		

3) Please list any current medications (and amounts, times per day);		
<i>(including aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):</i>		

Social History:		
	<u>Yes</u> <u>No</u>	Please list details below:
Do you smoke? List how much	<input type="checkbox"/> <input type="checkbox"/>	_____
If no, did you smoke previously	<input type="checkbox"/> <input type="checkbox"/>	_____
How often do you drink alcohol?		_____
What type of alcohol do you prefer?		_____
What is your occupation?		_____
Family History:		
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:		
If yes, please indicate which relative(s) have the problem		
	<u>Yes</u> <u>No</u>	
Hearing problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Allergy	<input type="checkbox"/> <input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/> <input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/> <input type="checkbox"/>	_____
		Reviewed by:

