Medical Health History Record Name: _____ DOB: _____

Confidential

What is the primary reason for your visit today?

_____

Date of last physical exam: _____/_____/_____ For women Date of last Pap Smear: _____/_____/_____

Medications

List any medications you are taking: _____

_____

_____

Allergies

List any known allergies & medication allergies: _____

_____

_____

****Pharmacy****

List pharmacy name and location:_____

_____

Symptoms *Check any you currently have or had in the past year		**Briefly explain any checked.**
☐ **GENERAL** (chills, depression, dizziness, fainting, fever, forgetfulness, headache, loss of sleep, loss of weight, nervousness, numbness, sweats)	☐ NONE	
☐ **EYE, EAR, NOSE, THROAT** (blurred vision, difficulty swallowing, double vision, earache, ear discharge, hoarseness, loss of hearing, nosebleeds, persistent cough, ringing in ears, sinus problems)	☐ NONE	
☐ **CARDIOVASCULAR** (chest pain, high blood pressure, irregular heartbeat, low blood pressure, poor circulation, rapid heartbeat, swelling of ankles, varicose veins)	☐ NONE	
☐ **RESPIRATORY**	☐ NONE	
☐ **GASTROINTESTINAL** (poor appetite, bloating, bowel changes, constipation, diarrhea, excessive hunger, excessive thirst, gas, hemorrhoids, indigestion, nausea, rectal bleeding, stomach pain, vomiting, vomiting blood)	☐ NONE	
☐ **GENITO-URINARY** (blood in urine, frequent urination, lack of bladder control, painful urination)	☐ NONE	
☐ **MUSCLES/JOINTS/BONES** Pain, weakness, numbness in: arms, back, feet, hands, hips, legs, neck, shoulders.	☐ NONE	
☐ **SKIN** (bruise easily, hives, itching, change in moles, rash, scars, sore that won't heal)	☐ NONE	
☐ **NEUROLOGICAL**	☐ NONE	
☐ **PSYCHIATRIC**	☐ NONE	
☐ **HORMONAL/ENDOCRINE**	☐ NONE	
☐ **BLOOD/ LYMPHATIC**	☐ NONE	
☐ **INFECTIOUS DISEASES**	☐ NONE .	

PLEASE SEE BACK ->

Medical Health History Record Name: _____ DOB: _____

FAMILY HISTORY			Relationship to You
Diabetes	☐YES	☐NO	
_____			_____
Heart Disease	☐YES	☐NO	
_____			_____
Cancer	☐YES	☐NO	
_____			_____
Other	☐YES	☐NO	
_____			_____

SOCIAL HISTORY

Do you smoke? ☐ YES ☐NO

Packs per day? _____

Were you a smoker in the past ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

How frequently do you drink?

_____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature_____ Date_____