

Height \_\_\_\_\_

Date \_\_\_\_\_

Weight \_\_\_\_\_

Age \_\_\_\_\_



Please complete the following **Medical History** form prior to seeing the doctor or PA.  
 (Feel free to use the back side for more space for your answers)

Name: \_\_\_\_\_ record number: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

How long has this been going on? \_\_\_\_\_

What medicine have you taken for this problem? \_\_\_\_\_

Name of family/medical doctor: \_\_\_\_\_ Did he/she refer you for this problem? \_\_\_

List all medical problems for which you take medicine: \_\_\_\_\_

List ALL current medicines (include over-the-counter medicines):

Are you allergic to any medicines? \_\_\_ Please list them: \_\_\_\_\_

All past surgeries / operations: \_\_\_\_\_

Do any diseases run in your family? If so, please list them. \_\_\_\_\_

What type of work, if any, do you do? (indicate if disabled or retired) \_\_\_\_\_

Living situation: \_\_\_ alone \_\_\_ with spouse \_\_\_ with other relative (\_\_\_\_) \_\_\_ nursing home

Do you use tobacco? \_\_\_yes \_\_\_no. If yes, what type, and how much? \_\_\_\_\_

Do you drink alcohol? \_\_\_yes \_\_\_no. If yes, how much per day/week? \_\_\_\_\_

Are your parents living? \_\_\_yes \_\_\_no. Age and cause of death: \_\_\_\_\_

Have you ever had:

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Broken bone      | <input type="checkbox"/> Elbow pain      | <input type="checkbox"/> Pain down leg |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Hand numbness   | <input type="checkbox"/> Knee injury   |
| <input type="checkbox"/> Stroke       | <input type="checkbox"/> Neck stiffness   | <input type="checkbox"/> Hand arthritis  | <input type="checkbox"/> Flat feet     |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Shoulder pain    | <input type="checkbox"/> Back pain       | <input type="checkbox"/> Foot pain     |
| <input type="checkbox"/> Gout         | <input type="checkbox"/> Shoulder popping | <input type="checkbox"/> Pain in buttock | <input type="checkbox"/> Heel pain     |

Do you now have any of the following problems?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Chills            | <input type="checkbox"/> Stomach ulcers    | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> fever             | <input type="checkbox"/> Sensitive stomach | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> <b>None of the</b> |
| <input type="checkbox"/> Weight loss       | <input type="checkbox"/> Cough             | <input type="checkbox"/> Back pain         | <input type="checkbox"/> <b>above</b>       |
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Shortness of      | <input type="checkbox"/> Joint pain        |   |
| <input type="checkbox"/> Double vision     | breath                                     | <input type="checkbox"/> Hand numbness     |   |
| <input type="checkbox"/> Blurred vision    | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hand weakness     |   |
| <input type="checkbox"/> Nosebleed         | <input type="checkbox"/> Chest pains       | <input type="checkbox"/> Arthritis         |   |
| <input type="checkbox"/> Cold or flu       | <input type="checkbox"/> Heart murmur      | <input type="checkbox"/> Balance problems  |   |
| <input type="checkbox"/> Nausea / vomiting | <input type="checkbox"/> Heart arrhythmia  | <input type="checkbox"/> Diabetes          |   |

Date reviewed: \_\_\_\_\_ revised 8-26-05