Medical Information

Past Medical History (list any significant illnesses or surgeries and the approximate date):_____
_____
_____
_____

Family Medical History (list significant illnesses in your family, either past or current): _____
_____
_____

Social History (e.g. smoke? drink? social drugs? contact lenses? living arrangements?): _____
_____

Medications you are taking: _____
_____
_____

Allergies: _____

Review of Systems: Height: _____ Weight: _____

If you are having problems with any of the following, please explain your problem:

General (fatigue, appetite, fever, sweats):_____
Eyes (blurred vision, drainage, etc.): _____
Ears, nose, throat, mouth: _____
Respiratory (shortness of breath, cough, etc.):_____
Cardiovascular (chest pain, shortness of breath, etc.):_____
Gastrointestinal (abnormal bowel movements, blood in stool, constipation, diarrhea, etc.): _____
_____
Genitourinary (problems urinating, etc.): _____

Women: Are you pregnant: Yes _____ No _____
Do you have regular menstrual periods: Yes _____ No _____

Men: Are you having prostate problems (frequent urination, difficulty starting to urinate)?
Yes _____ No _____

Heme/lymph (bruising, bleeding, swollen glands, etc.): _____
Have you ever had a blood transfusion? Yes _____ No _____
Skin (rashes, etc.): _____
Neurological (tremors, headaches, dizziness, seizures, etc.): _____
Psych (depression, anxiety): _____
Musculoskeletal (muscle weakness/pain, etc.): _____
Endocrine (weight loss/gain; thirst): _____

Do you have any disease, condition or problem not listed above: _____
_____
_____

Have you ever tested positive for Hepatitis: Yes _____ No _____ HIV: Yes _____ No _____

Do you have a living will: Yes _____ No _____

Name (first and last) and address of your primary care physician: _____
_____
Date of your last physical examination: _____
Name(s) of other physicians involved in your health care: _____
_____