Name _____ Age _____ Single / Married / Divorced / Widow(er) Date _____

Occupation _____ All Previous Occupations _____

Birth Place _____ Birthdate _____ List all States in which you have lived _____

Education: _____ years High School _____ years College _____ years Post Grad

Date of last physical examination _____

Please list all Symptoms

1. _____
2. _____
3. _____
4. _____
5. _____

Routine Check-up - No Symptoms ☐

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

PATIENT SIGNATURE _____

PHYSICIAN'S REVIEW SIGNATURE _____

	If Living Age	Health	If Deceased Age at death	Cause	Has any blood relative ever had:	Please encircle No or Yes		Who
Father					Cancer	No	Yes	
Mother					Tuberculosis	No	Yes	
Brother or Sister 1.					Diabetes	No	Yes	
2.					Heart Trouble	No	Yes	
3.					High Blood Pressure	No	Yes	
4.					Stroke	No	Yes	
Husband or Wife					Epilepsy	No	Yes	
Son or Daughter 1.					Insanity	No	Yes	
2.					Suicide	No	Yes	
3.								
4.								

PERSONAL HISTORY

ILLNESSES: Have you ever had

PLEASE ENCIRCLE ALL ANSWERS	No	Yes
Measles	No	Yes
German Measles	No	Yes
Mumps	No	Yes
Chicken Pox	No	Yes
Whooping Cough	No	Yes
Scarlet fever or Scarlatina	No	Yes
Diphtheria	No	Yes
Smallpox	No	Yes
Pneumonia	No	Yes
Influenza	No	Yes
Pleurisy	No	Yes
Rheumatic Fever or Heart Disease	No	Yes
Arthritis or Rheumatism	No	Yes
Any bone or joint disease	No	Yes
Neuritis or Neuralgia	No	Yes
Bursitis, Sciatica or Lumbago	No	Yes
Polio or Meningitis	No	Yes
Nephritis	No	Yes
Gonorrhea or Syphilis	No	Yes
Gallbladder disease	No	Yes
Anemia	No	Yes
Jaundice	No	Yes
Bladder disease	No	Yes
Epilepsy	No	Yes
Migraine headaches	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High or low blood pressure	No	Yes
Colitis or other bowel disease	No	Yes
Hemorrhoids or any rectal disease	No	Yes
Nervous Breakdown	No	Yes
Food, chemical or drug poisoning	No	Yes
Hay fever or Asthma	No	Yes
Hives or Eczema	No	Yes
Frequent infections or boils	No	Yes
AIDS	No	Yes
Any other disease	No	Yes

ALLERGIES: Are you allergic to

Penicillin or Sulfa	No	Yes
Aspirin, Codeine or Morphine	No	Yes
Mycins or other Antibiotics	No	Yes
Merthiolate or Mercurochrome	No	Yes
Any other drug	No	Yes
Any foods	No	Yes
Adhesive Tape	No	Yes
Nail polish or other cosmetics	No	Yes
Tetanus Antitoxin or Serums	No	Yes

INJURIES: Have you had any

Broken or cracked bones	No	Yes
Sprains	No	Yes
Lacerations	No	Yes
Dislocations	No	Yes
Concussion, or head injury	No	Yes
Ever been knocked unconscious	No	Yes

WEIGHT: Now _____ One Year Ago _____

Maximum _____ When _____

TRANSFUSIONS: Have you ever had

Blood or Plasma Transfusion	No	Yes

SURGERY: Have you had

Tonsillectomy	No	Yes
Appendectomy	No	Yes
Any other operation	No	Yes

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Do you smoke No Yes

How many per day _____

Have you ever been advised to have any surgical operation which has not been done _____ No Yes

Have you been hospitalized for any illness _____ No Yes

Give details:

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches ____ No Yes
Fainting spells ____ No Yes
Dizziness on change of position ____ No Yes
Unconscious Spells ____ No Yes
Blurred Vision ____ No Yes
Double Vision ____ No Yes
Spots before eyes ____ No Yes
Infected eyes ____ No Yes
Pain behind eyes ____ No Yes
Any change in vision ____ No Yes
Do you wear glasses ____ No Yes
When were they last checked ____
Earaches ____ No Yes
Discharge from Ears ____ No Yes
Ringing in ears ____ No Yes
Decrease in hearing ____ No Yes
Recurrent nose bleeds ____ No Yes
Recurrent head colds ____ No Yes
Sinus Trouble ____ No Yes
Hay fever ____ No Yes
Strange persistent odors ____ No Yes
Strange taste or loss in taste ____ No Yes
Persistent hoarseness ____ No Yes
Difficulty swallowing ____ No Yes
Enlarged glands ____ No Yes
Recurrent sore throats ____ No Yes
Recurrent sores in mouth ____ No Yes
Soreness or bleeding of gums on brushing ____ No Yes
Chest pain ____ No Yes
Angina pectoris ____ No Yes
Coughed up blood ____ No Yes
Pain in arm(s) ____ No Yes
Night sweats ____ No Yes
Chronic or frequent cough ____ No Yes
Chronic or frequent cough on lying down ____ No Yes
Wake up at night short of breath ____ No Yes
How many bed pillows do you use ____ ____
Shortness of breath on:
Walking several blocks ____ No Yes
One flight of stairs ____ No Yes
On lying down ____ No Yes
Purple lips or fingers ____ No Yes
Palpitations or fluttering of heart ____ No Yes
High blood pressure ____ No Yes
Swelling of hands, feet or ankles ____ No Yes
At what time of day ____
Leg cramps on walking or at night ____ No Yes
Enlarged veins in legs ____ No Yes
Recurrent stomach pain ____ No Yes
Belching or heartburn ____ No Yes
Relieved by food or medication ____ No Yes
Appetite - Good ☐ Fair ☐ Poor ☐
Nausea or vomiting ____ No Yes
Vomited blood ____ No Yes
Avoid some foods ____ No Yes
What kinds ____
Avoid spices ____ No Yes
Abdominal cramping ____ No Yes
Color of bowel movement ____
Any blood in BM ____ No Yes
Rectal pain with bowel movement ____ No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape or texture of BM ____ No Yes
Describe ____
Pain on urinating ____ No Yes
Difficulty in starting urination ____ No Yes
Do you get up at night to urinate ____ No Yes
How many times ____
Urinate more than before ____ No Yes
Urinate less than before ____ No Yes
Any blood in urine ____ No Yes
How many times per day do you urinate ____
Full feeling of bladder, but only small amount of urination ____ No Yes
Lose urine on coughing or sneezing ____ No Yes
Discharge from penis ____ No Yes
Recurrent back pains ____ No Yes
Backaches ____ No Yes
Joint pains ____ No Yes
Swelling of any joints ____ No Yes
Redness or heat of any joint ____ No Yes
Tingling or weakness of hands or feet ____ No Yes
Muscle Spasms ____ No Yes
Loss or change in sensation of hands or feet ____ No Yes
Trembling of any extremity ____ No Yes
Growth in neck or throat ____ No Yes
Hot flashes ____ No Yes
Tiredness without apparent reason ____ No Yes
Brittleness of nails ____ No Yes
Dryness of skin ____ No Yes
Easy bruising ____ No Yes
Inability to stand heat ____ No Yes
Inability to stand cold ____ No Yes
Change in hair texture ____ No Yes
Change in skin texture ____ No Yes
Any skin rash ____ No Yes

X-RAYS: Have you ever had x-rays of
Chest ____ No Yes
Stomach or colon ____ No Yes
Gall bladder ____ No Yes
Extremities ____ No Yes
Back ____ No Yes
Teeth ____ No Yes
Other ____ No Yes
EKG: Ever had an electrocardiogram? ____ No Yes
IMMUNIZATIONS: Have you had
Smallpox vaccination within last 7 years ____ No Yes
Tetanus shots (not antitoxin which lasts only 2 weeks) ____ No Yes
Polio shots within last 2 years ____ No Yes

DRUGS: Laxitives; never ☐ occ. ☐ freq. ☐ daily ☐
Vitamins; never ☐ occ. ☐ freq. ☐ daily ☐
Sedatives; never ☐ occ. ☐ freq. ☐ daily ☐
Tranquilizers; never ☐ occ. ☐ freq. ☐ daily ☐
Sleeping pills, etc.; never ☐ occ. ☐ freq. ☐ daily ☐
Aspirin, etc.; never ☐ occ. ☐ freq. ☐ daily ☐
Cortisone, ACTH; never ☐ occ. ☐ freq. ☐ daily ☐
Thyroid; never ☐ yes, in past, none now ☐
daily ☐ now on ____ gr. day
Appetite depressants never ☐ occ. ☐ freq. ☐ daily ☐

Have you ever been treated for drug habits ____ No Yes
Have you ever taken insulin or tablets for diabetes ____ No Yes
Have you ever taken hormone tablets or injections ____ No Yes
SEX: Entirely satisfactory? ____ No Yes

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset ____
Regular? ☐ Yes ☐ No ☐ Varies
Cycle ____ days (from start to finish)
Flow: Heavy ☐ Medium ☐ Light ☐
Number of pads used per period ____
Any clots passed ____ No Yes
Pains or cramps ____ No Yes
Date of last period ____
Date of last pelvic exam ____
Date of last Pap Test ____
Results: ☐ Neg. ☐ Pos.
Any discharge from vagina ____ No Yes
If so, color ____
amount ____
Any itching of vaginal area ____ No Yes
Do you take birth control pills ____ No Yes
How long have you taken them ____
Pregnancies:
How many children born alive ____
How many still births ____
How many premature births ____
How many Cesarean Sections ____
How many miscarriages ____
Any complications with pregnancy ____ No Yes
Describe ____
Other ____