PATIENT MEDICAL HISTORY

Name _____ **Age** _____ **DOB** _____ **Date**_____

Years of Education (H.S. =12) _____ **Handed:** ☐ **Left** ☐ **Right** **Gender:** ☐ **Male** ☐ **Female**

Reason for Visit _____

_____

MEDICATIONS

Medication: Dose

FAMILY HISTORY
(Relatives, Excluding Self)

Disease	**No**	**Yes**
Alzheimer's	☐	
Headache	☐	
Cancer	☐	
Epilepsy	☐	
Heart Disease	☐	
High Blood Pressure	☐	
Diabetes	☐	
Stroke	☐	
Anxiety, Depression, Panic Attacks or OCD	☐	
Problems with Attention or Learning (i.e. AHDH)	☐	
Obesity	☐	
Other	☐	

Drug / Allergies

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

Do you smoke? ☐ Yes ☐ No

How much? _____

Do you drink Alcohol? ☐ Yes ☐ No

How much? _____

For Women Only

Menstrual Periods
☐ Regular ☐ irregular ☐ none

Last Menses _____

Are you taking birth control pills?
☐ Yes ☐ No

Is there a possibility you might be pregnant?
☐ Yes ☐ No

Are you trying to get pregnant?
☐ Yes ☐ No

Please Fill Out Page 2

Please circle below if you have had any of these symptoms/problems

Constitutional: fever / chills / significant weight loss or weight gain

Eyes: visual difficulties / double vision

Ears, Nose, Mouth, Throat: difficulty hearing / swallowing issues / sore throat / dizziness

Cardiovascular: chest pain / shortness of breath / high blood pressure / heart attack

Respiratory: any pulmonary issues / wheezing

Gastrointestinal: nausea / vomiting / diarrhea / blood in stool

Genitourinary: urinary difficulties / blood in urine

Musculoskeletal: recent injury / significant joint pain

Skin: rash / bruising

Neurologic: history of stroke / seizure / numbness / weakness / headache / neck pain / back pain

Psychiatric: sadness / depression / significant anxiety / suicidal

Endocrine: diabetes / thyroid problems

Hematologic / Lymphatic: low blood count / blood disorders

History of Cancer: yes / no type: _____

Surgeries or Hospitalizations	Date	Surgeries or Hospitalizations	Date
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____