



Patient Name \_\_\_\_\_

**PAST MEDICAL HISTORY & SYSTEMS REVIEW (check all that apply):**

- |                           |                           |                             |
|---------------------------|---------------------------|-----------------------------|
| Headaches _____           | Cancer _____              | Convulsions _____           |
| Blurred Vision _____      | Kidney Disease _____      | Seizures _____              |
| Hearing loss _____        | Yellow Jaundice _____     | Anxiety _____               |
| Fainting episodes _____   | Venereal Disease _____    | Depression _____            |
| Chest Pain _____          | Tuberculosis _____        | Thyroid problems _____      |
| Angina _____              | Bronchitis _____          | Diabetes _____              |
| Rheumatic Fever _____     | Shortness of Breath _____ | Hepatitis _____             |
| High Blood Pressure _____ | Emphysema _____           | Blood Transfusion _____     |
| Heart Attack _____        | Poor circulation _____    | Blood Disorders _____       |
| Swollen Ankles _____      | HIV/AIDS _____            | Pregnancy _____             |
| Skin Problems _____       | Incontinence _____        | Diarrhea/Constipation _____ |

List any additional Medical Problems below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY:**

Previous Operations:

- |          | Approximate Year |
|----------|------------------|
| 1. _____ | _____            |
| 2. _____ | _____            |
| 3. _____ | _____            |
| 4. _____ | _____            |
| 5. _____ | _____            |

Any previous fractures?  Yes  No      If yes, please describe: \_\_\_\_\_  
 Any serious injuries?  Yes  No      If yes, please describe: \_\_\_\_\_

**MEDICATIONS:**

Drug Allergies (please circle): NO YES (if yes please list which medicines) \_\_\_\_\_

Please list your current medications and dosage:

| Name of Drug | Dose  |
|--------------|-------|
| _____        | _____ |
| _____        | _____ |
| _____        | _____ |
| _____        | _____ |

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_ Job Duties: \_\_\_\_\_  
 Do you smoke?  Yes  No  In the past      If yes, how much? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No  
 Do you regularly wear your seat belt?  Yes  No

**FAMILY HISTORY (any history of parents or siblings with serious medical conditions):** NO YES  
 If yes, please list which family member and their medical problem \_\_\_\_\_

**DOCTOR ONLY: PLEASE DO NOT WRITE IN THIS BOX.**

I have reviewed this information with the patient:

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_