

Medical History

NAME: _____ DOB: _____ CHART #: _____

When was your last physical exam: _____

Physician's Name _____ Phone _____

MOBILITY: Active Moderate Needs Assistance

1. Are you currently under medical treatment Yes No
Please describe: _____

2. Have you ever had any serious illnesses or operations? Yes No
Please describe: _____

3. Are you currently taking any medication Yes No
Please describe: _____

4. Do you smoke Yes No

5. Do you use alcohol Yes No

6. Do you use cocaine or other drugs? Yes No

7. Have you had any allergic reactions to the following:

Local Anesthetics (eg. novocaine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin or other Antibiotics.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates (sleeping pills)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sedatives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Iodine.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please describe: _____

8. Review of Systems Check:

If you have no problems, check here.

Please check off if you have any problems in the various areas below. Please give a brief description.

General Health:

- Weight Loss Chills Night Sweats
- Poor Appetite Fatigue Insomnia
- Allergy/Immunology: _____
- Bones and Muscles: _____
- Endocrine: _____
- Eyes: _____
- Gastrointestinal: _____
- Genito/Urinary: _____
- Heart: _____
- Hematology: _____
- Lungs/Respiratory: _____
- Neurological: _____
- Psychiatric: _____
- Skin: _____

9. Women Only:

Do you have regular periods? Yes No

Are you taking birth control pills? Yes No

Have you every been pregnant? Yes No

Number of Pregnancies: _____

Have you ever had the following:

	Yes	No		Yes	No		Yes	No
Anemia (low blood count)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia (no appetite)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency (Addiction to drugs)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Measles.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
Cough - persistent or bloody.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		

SIGNATURE OF PATIENT/PARENT: _____

DATE: ____/____/____