

# MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you have problems with or are being treated for: (Circle all that apply)**

<p><b>General: None</b> <input type="checkbox"/></p> <p>Recent weight change</p> <p>Fatigue</p> <p>Fever</p> <p>Cancer (Type: _____) (Status: _____)</p> <p>Females: Currently Pregnant</p>	<p><b>Eyes: None</b> <input type="checkbox"/></p> <p>Cataract/Glaucoma</p> <p>Bells Palsy</p> <p>Eye Injury</p> <p>Iritis</p> <p>Macular Degeneration</p>	<p><b>Neurological: None</b> <input type="checkbox"/></p> <p>Headaches</p> <p>Seizures</p> <p>Paralysis</p> <p>Stroke</p> <p>Head Injury</p> <p>Multiple Sclerosis</p>
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**Gastrointestinal: None**

Loss of appetite

Nausea or vomiting

Diarrhea

Constipation

Heartburn

Ulcer

**Endocrine: None**

Glandular/hormonal

Thyroid disease

Diabetic  
(year diagnosed \_\_\_\_\_)

Type I or II

**Skin: None**

Change in skin color

Eczema/Rosacea

Rash or itching

**Ears/Nose/Throat/Mouth:**

**None:**

Chronic Sinus or Allergies

Hearing Loss

**Respiratory: None**

Shortness of breath

Asthma

Emphysema

COPD

Chronic or frequent cough

**Cardiovascular:**

**None:**

Heart trouble

Murmur

Palpitations

High Blood Pressure

**Genitourinary: None**

Incontinence

Prostate

Frequent urination

**Musculoskeletal:**

**None:**

Muscle/Joint Pain

Osteoporosis

Arthritis

**Hematological:**

**None:**

Anemia

Hepatitis A B C

Cholesterol

Slow to heal

**Immunologic: None**

Sjogrens syndrome

Lupus

Rheumatoid Arthritis

Other Conditions not mentioned above: \_\_\_\_\_

**Family History: M=Mother F=Father S=sibling GP=Grandparents**

Disease	Yes	No		Disease	Yes	No	
Glaucoma				Cataracts			
Cancer				Arthritis			
Heart				Diabetes			
Hypertension				Kidney			
Lupus				Stroke			
Thyroid				Other			

Alcohol Use: \_\_\_\_\_ Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily

Tobacco Use: \_\_\_\_\_ Currently Smoke: \_\_\_\_\_ pks per day X \_\_\_\_\_ yrs.  
 \_\_\_\_\_ Never Smoked \_\_\_\_\_ Quit: \_\_\_\_\_ (date)

Do you wear Dentures? \_\_\_\_\_ No \_\_\_\_\_ Yes: Full or Partial / Upper Lower or both.

Do you wear Hearing Aids? \_\_\_\_\_ No \_\_\_\_\_ Yes: Right Ear/Left Ear or both.

**(OVER)**

**Medications:**

Name	Strength	How often	Taking For

\*\*\*ARE YOU CURRENTLY TAKING OR HAVE YOU EVER TAKEN FLOMAX? YES or NO

**Surgical History:**

Surgery	Date

**Allergies:**

Name of Medication	Type of Reaction	When

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

office use only below this line

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PCP: \_\_\_\_\_ PHARMACY: \_\_\_\_\_

Date: \_\_\_\_\_ Rev. by: \_\_\_\_\_ AOTP? YES / NO      Date: \_\_\_\_\_ Rev by: \_\_\_\_\_ AOTP? YES / NO

Date: \_\_\_\_\_ Rev. by: \_\_\_\_\_ AOTP? YES / NO      Date: \_\_\_\_\_ Rev by: \_\_\_\_\_ AOTP? YES / NO

Date: \_\_\_\_\_ Rev. by: \_\_\_\_\_ AOTP? YES / NO      Date: \_\_\_\_\_ Rev by: \_\_\_\_\_ AOTP? YES / NO