MEDICAL HISTORY

Name:__________ D.O.B:__________ Today's Date:__________

Height:__________ Weight:__________

Pharmacy:__________ City:__________

Medical Doctor (PCP): __________

Tobacco use: _____Current _____Former _____Never Type:__________

Do you have problems with or are being treated for: (Put an "X" by all that apply):

General: None: ☐
- Cancer (Type:__________)
- (Status:__________)
- Females: Currently pregnant _____

Gastrointestinal: None: ☐
- Ulcer __________
- Reflu __________

Endocrine: None: ☐
- Hyperthyroidism__________
- Hypothyroidism__________
- Diabetic: Type I:_____Type II:_____
- (Year diagnosed:________)

Skin: None: ☐
- Eczema/Rosacea__________

Genitourinary: None: ☐
- Prostate __________
- Incontinence__________

Eyes: None: ☐
- Cataract/Glaucoma__________
- Bell's Palsy__________
- Eye injury__________
- (Describe:__________)
- Iritis__________
- Macular Degeneration __________

Ears/nose/throat/mouth: None: ☐
- Chronic sinus or allergies__________
- Hearing loss __________

Pulmonary: None: ☐
- Asthma __________
- Emphysema__________
- COPD __________
- Oxygen __________
- Sleep Apnea __________
- Chronic Bronchitis __________

Cardiovascular: None: ☐
- Murmur __________
- Palpitations__________
- High blood pressure __________

Neurological: None: ☐
- Seizures (When:__________)
- Paralysis__________
- Stroke__________
- Head injury__________
- Multiple Sclerosis__________

Musculoskeletal: None: ☐
- Osteoporosis __________
- Arthritis __________

Hematological: None: ☐
- Anemia __________
- Hepatitis A:____ B:____ C:________
- Cholesteral __________

Immunologic: None: ☐
- Sjogrens syndrome__________
- Lupus __________
- Rheumatoid Arthritis__________
- HIV/AIDS __________

Other conditions not mentioned above:__________

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MEDICAL HISTORY

Put an "X" by all that apply:

Dentures:	____ Yes or No	____ Full or Partial	____Upper	____Lower	____Both
Hearing aids:	____ Yes or No	____Right ear	____Left ear	____Both	

FAMILY HISTORY: M=Mother F=Father S=Siblings

DISEASE	YES	NO	RELATION	DISEASE	YES	NO	RELATION
Glaucoma				Cataracts			
Cancer				Arthritis			
Heart				Diabetes			
Hypertension				Kidney			
Lupus				Stroke			
Thyroid				Other			

MEDICATIONS: Bring a list of all medications, including over-the-counter meds to your appointment.

NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

Are you currently or have you ever taken Flomax? ____Yes ____No

Who prescribed this: ____

SURGICAL HISTORY:

SURGERY	DATE

ALLERGIES TO MEDICATIONS/BIOLOGICALS/MATERIALS:

PATIENT IS ALLERGIC TO:	TYPE OF REACTION	WHEN

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