MEDICAL HISTORY

Patient Name:_____DOB: _____ Date:_____

Referred By:_____ Age:_____ S M W D S

Menarche@:_____ Cycle:_____ Menopause @: _____

PAST MEDICAL HISTORY:

		PATIENT	(NOTES)	FAMILY	(NOTES)
1.	WEIGHT LOSS/GAIN	YES/NO		1. YES/NO	
2 .	HEADACHE/MIGRAINE	YES/NO		2. YES/NO	
3 .	HEART DISEASE	YES/NO		3. YES/NO	
4 .	HYPERTENSTION	YES/NO		4. YES/NO	
5 .	RESP DISEASE/ASTHMA	YES/NO		5. YES/NO	
6 .	BREAST DISEASE	YES/NO		6. YES/NO	
7 .	HEPATITIS/JAUNDICE	YES/NO		7. YES/NO	
8 .	GALLBLADDER DISEASE	YES/NO		8. YES/NO	
9 .	PEPTIC ULCER	YES/NO		9. YES/NO	
10.	HIATAL HERNIA	YES/NO		10. YES/NO	
11.	HEMORROIDS	YES/NO		11. YES/NO	
12.	RECTAL BLEEDING	YES/NO		12. YES/NO	
13	KIDNEY DISEASE	YES/NO		13. YES/NO	
14.	URINE/BLADDER INFECTION	YES/NO		14. YES/NO	
15.	URINARY INCONTINENCE	YES/NO		15. YES/NO	
16.	ANEMIA/BLOOD DISEASE	YES/NO		16. YES/NO	
17.	BLOOD TRANSFUSION	YES/NO		17. YES/NO	
18.	VARICOSE VEINS	YES/NO		18. YES/NO	
19.	PHLEBITIS	YES/NO		19. YES/NO	
20.	THYROID DISEASE	YES/NO		20. YES/NO	
21.	DIABETES	YES/NO		21. YES/NO	
22.	CANCER	YES/NO		22. YES/NO	
23.	EPILEPSY	YES/NO		23. YES/NO	
24.	NEUROLOGICAL DISORDER	YES/NO		24. YES/NO	
25.	ARTHRITIS/OSTEOPOROSIS	YES/NO		25. YES/NO	
26.	SKIN DISORDERS	YES/NO		26. YES/NO	
27.	TUBERCULOSIS	YES/NO		27. YES/NO	
28.	GASTRO-INTESTINAL	YES/NO		28. YES/NO	
29.	COLITIS	YES/NO		29. YES/NO	
30.	INFERTILITY/DES	YES/NO		30. YES/NO	
31.	OTHER DISEASE/DSO	YES/NO		31. YES/NO	
32.	SEXUALLY TRANSMITTED DIS.	YES/NO		32. YES/NO	

SURGICAL/HOSPTIAL HISTORY:

MONTH/YEAR **ILLNESS/OPERATION**

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

LIST PRGNANCIES/MISCARRIAGES:

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

MEDICATIONS:_____

_____

ALLERGIES:_____

SOCIAL HISTORY: **CIGARETTES**_____**PPD** **ALCOHOL**_____ **COFFEE**_____**CUPS/DAY**

DRUGS _____ **REGULAR EXERCISE**_____

COMMENTS:_____

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