



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: \_\_\_\_\_