

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name:

Account No.

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Medical History Form (p. 1): Please provide the following medical information to the best of your ability:

<b>Date:</b>	<b>Age:</b>	<b>List any ALLERGIES TO MEDICATIONS:</b>	
What problems are you here for today?			
<b>Past Medical History:</b>			
1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain:			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Stomach or Intestinal problems	<input type="checkbox"/> <input type="checkbox"/>
Hypertension (high blood press)	<input type="checkbox"/> <input type="checkbox"/>	Allergy problems / therapy	<input type="checkbox"/> <input type="checkbox"/>
Thyroid problems	<input type="checkbox"/> <input type="checkbox"/>	Kidney problems	<input type="checkbox"/> <input type="checkbox"/>
Heart Disease / cholesterol probs	<input type="checkbox"/> <input type="checkbox"/>	Neurological problems	<input type="checkbox"/> <input type="checkbox"/>
Respiratory problems	<input type="checkbox"/> <input type="checkbox"/>	Cancer	<input type="checkbox"/> <input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/>	Other Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/>
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):			
3) Please list any current medications (and amounts, times per day): (include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays / cold / sinus / allergy meds):			
<b>Social History:</b>		<b>Please list details below:</b>	
Do you smoke? List how much	<input type="checkbox"/> <input type="checkbox"/>		
If no, did you smoke previously?	<input type="checkbox"/> <input type="checkbox"/>		
How often do you drink alcohol?			
What type of alcohol do you prefer?			
What is your occupation?			
<b>Family History:</b>			
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicate which relative(s) have the problem			
	<u>Yes</u> <u>No</u>		
Hearing problems	<input type="checkbox"/> <input type="checkbox"/>		
Heart problems / murmurs	<input type="checkbox"/> <input type="checkbox"/>		
Allergy	<input type="checkbox"/> <input type="checkbox"/>		
Diabetes	<input type="checkbox"/> <input type="checkbox"/>		
Cancer	<input type="checkbox"/> <input type="checkbox"/>		
Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>		
Anesthesia problems	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> See attached dictation	Reviewed by:

