MEDICAL HISTORY

PRINT FULL NAME________________________________ **DATE COMPLETED**____________

FAMILY HISTORY: Has any **blood relative** had any of the following? If so, what relationship?

Circle (yes) or (no) Comments

Condition	Circle	Comments
Anemia	YES/NO	____________
Bleeding Tendency	YES/NO	____________
Leukemia	YES/NO	____________
Repeated Infections	YES/NO	____________
Crippling arthritis	YES/NO	____________
Heart disease	YES/NO	____________
Chronic lung disease	YES/NO	____________
Tuberculosis	YES/NO	____________
High Blood Pressure	YES/NO	____________
Kidney disease	YES/NO	____________
Asthma	YES/NO	____________
Sever allergies	YES/NO	____________
Mental illness	YES/NO	____________
Convulsions/fits	YES/NO	____________
Migraine headaches	YES/NO	____________
Diabetes	YES/NO	____________
Gout	YES/NO	____________
Obesity	YES/NO	____________
Thyroid trouble	YES/NO	____________
Peptic ulcer	YES/NO	____________
Chronic diarrhea	YES/NO	____________
Cancer	YES/NO	____________
Other	YES/NO	____________

L=Living D=Deceased	Present age Age at death	Any health problems? Cause of death?
Father		
Mother		
Brothers/Sisters		
1		
2		
3		
4		
5		
6		
Children		
1		
2		
3		
4		
5		
6		
7		

PERSONAL HISTORY

Birthplace __________________Date_________

Nationality ________________Religion_________

Marital status _____Health of Spouse___________

Occupations______________________________

____

Residence past 5 years______________________

Education through ______________grade_______

Type of Home_____________________________

Habits-Sleep______________________hrs/night

Temperament_____________________________

Recreation_______________________________

Exercise_________________________________

Average per day:

Alcohol (type)__________________________

Tobacco (type)__________________________

Tea, Coffee_____________________________

Allergies_________________________________

Medicines taken regularly (include over-the-counter)

____

____

Surgeries/hospitalizations (not mentioned elsewhere)

____

____

PAST HISTORY: Have you ever had...?

Circle **(yes) or (no)**		**Year**			**Year**
Measles	yes/no	______	Nose bleeds	yes/no	______
Mumps	yes/no	______	Ulcer	yes/no	______
Whooping cough	yes/no	______	Cancer	yes/no	______
Polio	yes/no	______	Hemorrhoids	yes/no	______
Scarlet Fever	yes/no	______	Blood transfusion	yes/no	______
Diphtheria	yes/no	______	**OPERATIONS**		
Meningitis	yes/no	______	Tonsils	yes/no	______
Infectious Mono	yes/no	______	Appendix	yes/no	______
Valley Fever	yes/no	______	Gallbladder	yes/no	______
Tuberculosis	yes/no	______	Stomach	yes/no	______
Exposure to TB	yes/no	______	Breast	yes/no	______
Malaria	yes/no	______	Uterus/ovary	yes/no	______
Bronchitis	yes/no	______	Prostate	yes/no	______
Pneumonia	yes/no	______	Hernia	yes/no	______
Pleurisy	yes/no	______	Thyroid	yes/no	______
Hepatitis	yes/no	______	Varicose Veins	yes/no	______
Yellow Jaundice	yes/no	______	Hemorrhoids	yes/no	______
Bladder infections	yes/no	______	Heart	yes/no	______
Rheumatic Fever	yes/no	______	**INJURIES**		
Kidney disease	yes/no	______	Head	yes/no	______
Hives	yes/no	______	Chest	yes/no	______
Glaucoma	yes/no	______	Abdomen	yes/no	______
Hay fever/sinusitis	yes/no	______	Broken Bones	yes/no	______
Asthma	yes/no	______	Back	yes/no	______
Back trouble	yes/no	______	**ALLERGIES**		
High Blood Pressure	yes/no	______	Tetanus antitoxin	yes/no	______
Heart disease	yes/no	______	Penicillin	yes/no	______
Anemia	yes/no	______	Sulfa	yes/no	______
Bleeding tendency	yes/no	______	Other Drugs	yes/no	______

Other problems:____

Please comment:_______________________________________

____

MEDICAL HISTORY

Have **you** ever had any of the following? Circle **(yes)** or **(no)** If in doubt, leave blank.

General:

Tire easily/weakness	yes/no
Marked weight changes	yes/no
Night sweats	yes/no
Persistent fever	yes/no
Sensitivity to heat	yes/no
Sensitivity to cold	yes/no
Lumps/Masses felt	yes/no

Skin:

Sores that do not heal	yes/no
Enlarging/changing moles	yes/no
Eruptions (rash)	yes/no
Change in color	yes/no
Change in hair	yes/no
Change in nails	yes/no

Eyes:

Trouble seeing	yes/no
Eye Pain	yes/no
Inflamed eyes	yes/no
Double vision	yes/no
Worn glasses	yes/no

Ears:

Loss of hearing	yes/no
Ringing in ears	yes/no
Discharge (drainage)	yes/no

Nose:

Loss of smell	yes/no
Frequent colds	yes/no
Obstruction	yes/no
Excess discharge	yes/no
Nosebleeds	yes/no

Mouth:

Sore gums	yes/no
Soreness of tongue	yes/no
Dental problems	yes/no
Changes in color/ Texture of lining	yes/no

Are you on a special diet?
If yes, please describe:

____
____
____
____
____
____

Digestive Systems:

Change in appetite	yes/no
Difficulty swallowing	yes/no
Heartburn	yes/no
Abdominal enlargement	yes/no
Jaundice	yes/no
Nausea	yes/no
Vomiting	yes/no
Vomiting blood	yes/no
Rectal bleeding	yes/no
Black/tarry stools	yes/no
Constipation	yes/no
Change in shape of bowel movements	yes/no
Diarrhea	yes/no
Hemorrhoids	yes/no
Need of laxatives	yes/no

Throat:

Postnasal drip	yes/no
Soreness	yes/no
Hoarseness	yes/no

Cardio-Respiratory System:

Cough, persisting	yes/no
Sputum (phlegm)	yes/no
Bloody sputum	yes/no
Wheezing	yes/no
Chest pain/discomfort	yes/no
Pain on breathing	yes/no
Shortness of breath	yes/no
Difficulty breathing	yes/no
while lying down	yes/no
Swelling of ankles	yes/no
Bluish fingers/lips	yes/no
High blood pressure	yes/no
Palpitations	yes/no
Vein Trouble	yes/no

Breasts:

Lumps	yes/no
Discharge	yes/no

Genitourinary System:

Difficulty with erection	yes/no
Feel need to urinate without much urine	yes/no
Unable to hold urine	yes/no
Pain or burning	yes/no
Blood in urine	yes/no
Lack of sex drive	yes/no
Increase in frequency of urination (daily)	yes/no
Increase in frequency (night)	yes/no

Endocrine:

Thyroid trouble	yes/no
Adrenal trouble	yes/no
Cortisone Treatment	yes/no
Diabetes	yes/no

Locomotor:

Muscle cramps	yes/no
Muscle weakness	yes/no
Pain in joints	yes/no
Swollen joints	yes/no
Stiffness	yes/no
Deformity of joins	yes/no

Nervous System:

Headaches	yes/no
Dizziness	yes/no
Fainting	yes/no
Convulsions/fits	yes/no
Nervousness	yes/no
Sleeplessness	yes/no
Depression	yes/no
Change in sensation	yes/no
Memory loss	yes/no
Poor coordination	yes/no
Weakness/paralysis of muscles	yes/no

Physician's Comments______________________________

____
____
____
____
____
____
____