

HEALTH INFORMATION FOR YOUR PHYSICIAN

NAME: _____ Date: _____ DOB: _____ Age: _____

Phone #: _____ / (Cell) _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Include your symptoms and when they began: _____

What other physicians have you seen for this problem? _____

Have you had x-rays, CT scan or MRI scan for this problem? Yes No

Are you left or right handed? _____

Current problem is the result of a(n): Check all that apply:

Car Accident Work Accident Accident Other

MEDICAL HISTORY

Are you currently having or have had problems with:

	Circle	Describe all Yes responses
Eyes, Glaucoma	No Yes	_____
Ears, Nose, Throat, Hearing	No Yes	_____
Dental problems	No Yes	_____
Lungs, Breathing, Asthma	No Yes	_____
Digestion, Ulcers	No Yes	_____
Diabetes	No Yes	_____
High Blood Pressure	No Yes	_____
Heart Trouble, Heart Attack, Murmurs	No Yes	_____
Irregular Heart Beat	No Yes	_____
Infections, TB	No Yes	_____
Kidney disease	No Yes	_____
Bleeding problems	No Yes	_____
Blood Clots	No Yes	_____
Balance problems, Blackouts	No Yes	_____
Stroke	No Yes	_____
Psychological problems	No Yes	_____
AIDS/ HIV Positive results	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Rheumatoid Arthritis	No Yes	_____
Polio	No Yes	_____
Epilepsy/ Seizures	No Yes	_____
Hepatitis/ Jaundice	No Yes	_____
Reflux	No Yes	_____
Emphysema	No Yes	_____
Thyroid	No Yes	_____

List any Surgeries/ Hospitalizations: _____

(see other side)

MEDICATIONS

List your medications and herbs and their doses: _____

ALLERGIES: Are you allergic to any medications? Yes No

Please list the medications you are allergic to: _____

Have any problems with anesthesia? No Yes Describe: _____

SOCIAL HISTORY

Employed (occupation) _____
 Student Retired
 Single Married Divorced Separated Widowed
Children? No Yes How Many? _____

If necessary is anyone available to care for you at home? Yes No

History of substance abuse? No Yes What? _____

Smoke currently? No Yes _____ Packs per day for _____ years.

Quit smoking? _____ When? _____ Previously smoked _____ packs per day for _____ years.

Drink alcohol? No Yes How many drinks per day / week? _____
(circle)

FAMILY HISTORY

Please check family history conditions:

- Blood Clots Diabetes Hypertension Rheumatoid Arthritis
 Cancer Heart Disease Osteoporosis Stroke / Seizures

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **M.D. Date:** _____