MEDICAL HISTORY FORM

NAME_____DATE_____AGE_____

REASON FOR TODAY'S VISIT(cc) _____

HEIGHT_____ WEIGHT_____

PAST MEDICAL HISTORY: (please circle yes or no and elaborate if necessary)

			DESCRIBE
HIGH BLOOD PRESSURE	Y	N	
HEART DISEASE	Y	N	
ASTHMA	Y	N	
COPD/EMPHYSEMA	Y	N	
ALLERGIES	Y	N	
CHRONIC BACK/NECK PAIN	Y	N	
KIDNEY DISEASE	Y	N	
GASTROINTESTINAL PROBLEMS	Y	N	
MIGRANE HEADACHES	Y	N	
STROKE/TIA/MINI STROKE	Y	N	
DEPRESSION/ANXIETY	Y	N	
NEUROLOGIC DISORDER	Y	N	
CANCER (list type/treatment/date)	Y	N	
DIABETES	Y	N	
THYROID DISEASE	Y	N	
VISION/EYE PROBLEMS	Y	N	
AUTOIMMUNE DISEASE	Y	N	
SERIOUS CHILDHOOD ILLNESS	Y	N	
OTHER			
RECENT OPERATIONS or PREVIOUS ENT SURGERY	Y	N	

CURRENT MEDICATIONS: (use back of form for additional, or attach list)

MEDICATION	DOSE	DIRECTIONS FOR USE	REASON FOR USE	DATE STARTED

ALLERGIES: (list medication and reaction) _____

TOBACCO USE: ❑ non-smoker, ❑ former smoker, ❑current smoker, ❑smokless tobacco

TYPE_____AMOUNT/DAY_____HOW MANY YEARS_____YEAR ENDED_____

ALCOHOL USE: Average amount daily _____ Heavier in Past? _____

RECREATIONAL DRUGS: Type_____ Current or Past _____