

**MEDICAL HISTORY FORM**

Please Print:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Address \_\_\_\_\_

Social Security No. \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

**PERSONAL HISTORY****Physical Condition:** Do you exercise regularly? \_\_\_\_\_ Doing what? \_\_\_\_\_

Current Weight \_\_\_\_\_ Weight 2 Yrs. Ago \_\_\_\_\_ Are You "In Shape" \_\_\_\_\_

**Smoking:** Do you smoke? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ Packs Per Day \_\_\_\_\_

Age at which started \_\_\_\_\_ Year you quit smoking \_\_\_\_\_

Alcohol: How often do you drink? \_\_\_\_\_ Usual number of drinks \_\_\_\_\_

Caffeine: How many cups per day? \_\_\_\_\_

Salt/Fast Food: Do you prefer a lot of salt? \_\_\_\_\_ Do you eat a lot of fast food? \_\_\_\_\_

Drugs: Do you smoke marijuana? \_\_\_\_\_

Sexual: Have you ever had a venereal disease? \_\_\_\_\_

Sexual Preference: Heterosexual (straight) \_\_\_\_\_ Homosexual (gay) \_\_\_\_\_

Have you ever received a blood transfusion: \_\_\_\_\_ Ever had hepatitis? \_\_\_\_\_

Ever been tested for AIDS? \_\_\_\_\_ If yes, result \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ How is your eyesight (with Glasses)? \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_

How is your hearing? \_\_\_\_\_ Do you wear dentures? \_\_\_\_\_

**MEDICAL HISTORY**

LIST ANY AND ALL KNOWN MEDICAL PROBLEMS:

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

(4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_

LIST ANY AND ALL SURGERY YOU HAVE HAD WITH APPROXIMATE DATES:

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

(4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_

HAVE YOU EVER HAD ANY ANESETHIA PROBLEMS? \_\_\_\_\_

LIST ALL MEDICATIONS YOU TAKE:

(Include Tylenol, Aspirin, Birth Control Pills, vitamins &amp; herbal remedies)( with dosage and frequency):

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

(4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

DATE YOU WERE LAST HOSPITALIZED: \_\_\_\_\_ REASON: \_\_\_\_\_

**DATE OF LAST:** TETANUS BOOSTER INJECTION \_\_\_\_\_ CHEST X-RAY \_\_\_\_\_TUBERCULOSIS SKIN TESTING \_\_\_\_\_ RESPONSE:  POSITIVE  NEGATIVE

PNEUMOVAX \_\_\_\_\_ HEP B \_\_\_\_\_ HEP A \_\_\_\_\_ MMR \_\_\_\_\_

### FAMILY HISTORY

**MOTHER:**

Is your mother Alive? \_\_\_\_\_ How old is she? (or) \_\_\_\_\_ How old was she when she died? \_\_\_\_\_

If deceased, what did she die from: \_\_\_\_\_

Does She (Did She) Smoke? \_\_\_\_\_

Does she have (or did she) have serious health problems during life? \_\_\_\_\_ If yes, What: \_\_\_\_\_

**FATHER:**

Is your father Alive? \_\_\_\_\_ How old is he? (or) \_\_\_\_\_ How old was he when he died? \_\_\_\_\_

If deceased, what did he die from: \_\_\_\_\_

Does He (Did He) Smoke? \_\_\_\_\_

Does he have (or did he) have serious health problems during life? \_\_\_\_\_ If yes, What: \_\_\_\_\_

**BROTHERS & SISTERS:** Number of Brothers \_\_\_\_\_ Number of Sisters \_\_\_\_\_

**IS THERE A HISTORY OF:** (1) Diabetes \_\_\_\_\_ (2) High Blood Pressure \_\_\_\_\_ (3) Premature Heart Attack (Before Age 60) \_\_\_\_\_ (4) Premature Stroke (Before Age 60) \_\_\_\_\_ (5) Bleeding Disorders \_\_\_\_\_ (6) Ulcerative Colitis or Crohns Disease \_\_\_\_\_ (7) Breast Cancer \_\_\_\_\_ (8) Inheritable or Genetic Disease \_\_\_\_\_ (9) Migraine Headaches \_\_\_\_\_ (10) Asthma or Allergies \_\_\_\_\_ (11) Sickle Cell Anemia \_\_\_\_\_ (12) Anesthetic Allergies \_\_\_\_\_

### ORTHOPEDIC HISTORY

Have you ever had any of the following:

\_\_\_\_\_ major joint injury (ligament injury/dislocation) \_\_\_\_\_

\_\_\_\_\_ a fracture (broken bone) \_\_\_\_\_ leg pain \_\_\_\_\_

\_\_\_\_\_ arthritis \_\_\_\_\_ nerve/muscle injury \_\_\_\_\_

\_\_\_\_\_ back pain \_\_\_\_\_ numbness/tingling \_\_\_\_\_ neck pain \_\_\_\_\_

### GYN HISTORY (FEMALES ONLY)

First day of last menstrual period \_\_\_\_\_

Age at first period \_\_\_\_\_ How long do periods last? \_\_\_\_\_

How often do periods come? \_\_\_\_\_ Regular? \_\_\_\_\_

Method of contraception \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_ Any abnormal Pap Smears? \_\_\_\_\_

Have you ever had a venereal disease?(Please Circle) Gonorrhea Syphilis Herpes Genital Warts Chlamydia Trichomonas AIDS  
When? \_\_\_\_\_ Treatment? \_\_\_\_\_

History of DES Exposure? \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_ Do you perform self-breast exam? \_\_\_\_\_

Date of last Bone Density \_\_\_\_\_ Test Result: \_\_\_\_\_

Ever Used: IUD \_\_\_\_\_ Hormone Replacement Therapy \_\_\_\_\_

Number of times pregnant: \_\_\_\_\_ Number of times delivered: \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_

**PRIOR PREGNANCIES:**

DATE BORN	EARLY/DUE/LATE (How Much?)	BABY'S WEIGHT	SEX M/F	DELIVERY (Vaginal or C-section)	COMPLICATIONS	HOSPITAL/MD
				V C/S		
				V C/S		
				V C/S		
				V C/S		
				V C/S		

UPDATED BY PATIENT	DATE:	REVIEWED DATE:
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		

# AMS

## Alton MultiSpecialists

### DO YOU CURRENTLY HAVE PROBLEMS WITH:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headache                 | <input type="checkbox"/> Blood in Urine                   | <input type="checkbox"/> Speech Disorder          |
| <input type="checkbox"/> Migraines                | <input type="checkbox"/> Painful (Burning) Urination      | <input type="checkbox"/> Meningitis               |
| <input type="checkbox"/> Nosebleeds               | <input type="checkbox"/> Back Pain                        | <input type="checkbox"/> Memory Loss              |
| <input type="checkbox"/> Sinus Drainage           | <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Decrease in Libido       |
| <input type="checkbox"/> Ringing in Ears          | <input type="checkbox"/> Stiff Joints                     | <input type="checkbox"/> Sweating                 |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Skin Rashes                      | <input type="checkbox"/> Thyroid Problems         |
| <input type="checkbox"/> Chest Pains              | <input type="checkbox"/> Hives                            | <input type="checkbox"/> Fatigue                  |
| <input type="checkbox"/> Confusion                | <input type="checkbox"/> Hair Loss                        | <input type="checkbox"/> Fertility Problems       |
| <input type="checkbox"/> Ankle Swelling           | <input type="checkbox"/> Inability to Tolerate Heat       | <input type="checkbox"/> Problem with vision      |
| <input type="checkbox"/> Wheezing                 | <input type="checkbox"/> Inability to Tolerate Cold       | <input type="checkbox"/> Hearing Loss             |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Difficulty Swallowing            | <input type="checkbox"/> Loud Noise Exposure      |
| <input type="checkbox"/> Heart Palpitations       | <input type="checkbox"/> Pains in legs while walking/rest | <input type="checkbox"/> Nasal Polyps             |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Phlebitis/Blood Clots            | <input type="checkbox"/> Sneezing Fits            |
| <input type="checkbox"/> Insomnia                 | <input type="checkbox"/> Easy Bruising                    | <input type="checkbox"/> Allergy Reactions        |
| <input type="checkbox"/> Nervousness or Anxiety   | <input type="checkbox"/> Eczema                           | <input type="checkbox"/> Nasal Congestion         |
| <input type="checkbox"/> Chronic Cough            | <input type="checkbox"/> Skin Cancer                      | <input type="checkbox"/> Facial Pain              |
| <input type="checkbox"/> Smoker's Cough           | <input type="checkbox"/> Dryness                          | <input type="checkbox"/> Post Nasal Drip          |
| <input type="checkbox"/> Coughing Up Phlegm/Blood | <input type="checkbox"/> Itching                          | <input type="checkbox"/> Fractured/Broken (nasal) |
| <input type="checkbox"/> Abdominal Pains          | <input type="checkbox"/> Bad Scarring                     | <input type="checkbox"/> Snoring                  |
| <input type="checkbox"/> Indigestion              | <input type="checkbox"/> Suspicious Moles                 | <input type="checkbox"/> Voice Changes            |
| <input type="checkbox"/> Heartburn                | <input type="checkbox"/> Infections                       | <input type="checkbox"/> Hoarseness               |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Loss of Consciousness            | <input type="checkbox"/> Dental Problems          |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fainting Spells                  | <input type="checkbox"/> Gum Problems             |
| <input type="checkbox"/> Blood in Stool           | <input type="checkbox"/> Head Injury                      | <input type="checkbox"/> Mouth Ulcerations        |
| <input type="checkbox"/> Black, Tar-like Stools   | <input type="checkbox"/> Seizures                         |   |
| <input type="checkbox"/> Frequent Urination       |   |   |

### TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU EVER HAD:

- |   |  |
|---|--|
| <input type="checkbox"/> Measles                      | <input type="checkbox"/> A Concussion  |
| <input type="checkbox"/> Chicken Pox                  | <input type="checkbox"/> A Seizure (Epilepsy)                                |
| <input type="checkbox"/> Mono                         | <input type="checkbox"/> An Ulcer  |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> A Psychiatric Problem                               |
| <input type="checkbox"/> A Heart Murmur               | <input type="checkbox"/> A Blood Transfusion                                 |
| <input type="checkbox"/> An Irregular Pulse           | <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> A Fainting Spell             | <input type="checkbox"/> A Broken Bone                                       |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> A Serious Orthopedic Injury or Problem              |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Radiation Treatment to Tonsils or Adenoids          |
| <input type="checkbox"/> Anemia (Low Blood Count)     | <input type="checkbox"/> A Kidney Stone                                      |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Exposure to Toxic Chemicals, Asbestos, Silicon Dust |
| <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Household Exposure to Person with Tuberculosis      |
| <input type="checkbox"/> Frequent Ear Infections      | <input type="checkbox"/> Easy Bleeding or Bruising                           |
| <input type="checkbox"/> Bladder or Kidney Infections |  |