AMS
Alton MultiSpecialists

MEDICAL HISTORY FORM

Please Print:

Patient Name:_____ Date:_____

Patient Address_____
Street City Zip

Social Security No. _____ 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, Asprin, Birth Control Pills, vitamins & 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 _____

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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:		

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DO YOU <u>CURRENTLY</u> HAVE PROBLEMS WITH:

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

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

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

CONSENT FOR TREATMENT

I hereby authorize Alton MultiSpecialists physicians and staff to provide medical treatment and services to me and/or my minor child.

Signature (Parent/Guardian):_____Date:_____

Relationship to patient:_____