MEDICAL HISTORY FORM

Please Print: Patient Name:____Date:________________________

Patient Address____
Street City Zip

Social Security No. ___________________________ Date of Birth: _________________ Age:___________

Emergency Contact: ___________________________ Emergency Contact Phone Number:__________________

Referring Doctor:______________________________ Pharmacy Name:__________________________________

Employer Name:______________________________ Employer Phone Number:____________________________

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? ________If yes, year dentures acquired_____________________

How many pillows do you sleep on? ___________Do you wake up at night short of breath? ________________________________

Do you wake up at night to urinate? __________________If yes, how often? ____

Have you ever coughed up blood? ____________________ If yes, when?____

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 ________________

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 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: _______________________________

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? ____________________________

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:		

DO YOU CURRENTLY HAVE PROBLEMS WITH:

- ❑ Headache
- ❑ Migraines
- ❑ Nosebleeds
- ❑ Sinus Drainage
- ❑ Ringing in Ears
- ❑ Dizziness
- ❑ Chest Pains
- ❑ Fainting Spells
- ❑ 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
- ❑ Head Injury
- ❑ Seizures
- ❑ Confusion
- ❑ 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 providers and staff to provide medical treatment and services to me and/or my minor child.

Signature (Parent/Guardian):_________________________________ Date:___________________

Relationship to patient:_______________________________________