



Alton Multispecialists
1 Professional Drive
Alton, IL 62002

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, Aspirin, 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:

- | | | |
|---|---|---|
| <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"/> Fainting Spells | <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"/> Head Injury | <input type="checkbox"/> Gum Problems |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Seizures | <input type="checkbox"/> Mouth Ulcerations |
| <input type="checkbox"/> Black, Tar-like Stools | <input type="checkbox"/> Confusion | |
| <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 | |

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: _____