

COMPLETE MEDICAL HISTORY FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Date of Birth \_\_\_\_\_ AGE \_\_\_\_\_

Please describe your main problem \_\_\_\_\_

How long has this been present? \_\_\_\_\_

Is this the first time you had such a problem? \_\_\_\_\_

Other problems you wish to discuss? \_\_\_\_\_

What do you consider your health to be? EXCELLENT GOOD FAIR POOR

Are you \_\_\_\_\_ Right-handed? \_\_\_\_\_ Left-handed?

Do you consider yourself disabled? Y N

DATE	SURGERY	REASON	DOCTOR

Have you even been hospitalized for non-surgical reasons? If so, please explain \_\_\_\_\_

Have you ever had any of the following? Please check those that apply

<input type="checkbox"/>	Arthritis/bursitis	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Strokes
<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	TIA
<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Gall bladder problems
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Asthama	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Cancers List below	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	Hepatitis or jaundice
<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	pancreatitis
<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Venerial Disease
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Deformities
<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Loss of a limb
<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Rubella	<input type="checkbox"/>		<input type="checkbox"/>	

Other illnesses and date \_\_\_\_\_

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Accidents and date \_\_\_\_\_

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Do you exercise on a regular basis? Y N How much / often? \_\_\_\_\_

Do you use tobacco or smoke? Y N How much / often? \_\_\_\_\_

Do you consume Alcohol? Y N How much / often? \_\_\_\_\_

Do you have a history of drug abuse Y N

List medication and dosages

Medication	Strength	Frequency

Have you even been on prednisone? Y N Coumadin Y N

Please list any drug allergies you have and your reaction

Medication	Reaction

Do you have a special diet or food allergies \_\_\_\_\_

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Please give your family history

Maurice Jove M.D.    Jeff Traub M.D.    Scott Barbour M.D.  
 Brian Vanderhoof D.O.    Jason Billingham M.D.

	Living / Age	Deceased	Age and Cause of Death
Father			
Mother			
Siblings			

Is there a family history of?

	Heart Disease		Cancer
	Hypertension		Bone or muscle disease
	Diabetes		Died from anesthesia
	Kidney disease		

In the past SIX Months, have you had any of the following?

	Weight gain / loss		Shortness of breath
	Frequent headaches		Chest pain
	Head injury		Abnormal EKG
	Loss of memory		Chronic cough
	Ear, nose, or throat problems		Coughing up blood
	ringing in ears		Indigestion
	Eye problems		Jaundice
	Nose bleeds		Numbness
	Frequent colds		Painful urination
	Frequent sore throats		Foot trouble
	Difficulty / pain with swallowing		Sugar or albumin in urine
	Severe gum or tooth trouble		Frequent urination
	Recurrent back pain		Bowel or bladder difficulty
	Frequent diarrhea		Bloody bowel movements
	Black stools		Recurrent nausea or vomiting
	Fatty food intolerance		Black outs
	Depression or worry		Painful / red swollen joints
	Weakness / pain in muscles or joints		

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Signature