# MEDICAL HISTORY/FAMILY HISTORY

Name ______________________ DOB ____________

What is the reason for your visit today? ______________________

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*** Please check the family member(s) in which the condition applies.***

| Condition | Family member(s) |
|---|---|
| **Diabetes** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Heart Disease** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **High Blood Pressure** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Lung/Asthma** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Hearing Loss** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Cancer** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| ***AIDS/HIV** (SELF) | ☐ YES ☐ NO |
| **Bleeding Problems** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Anesthesia Problems** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Kidney Disease** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Stroke** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Thyroid** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| **Dementia/Alzheimer's** | ☐ Self ☐ Mother ☐ Father ☐ Bro ☐ Sis |
| ***HEPATITIS C** (SELF) | ☐ YES ☐ NO |

**List past surgeries/hospitalizations:**

☐ No Past Surgeries/Hospitalizations

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**Social History:**

Do you smoke? ☐ YES ☐ NO

Former smoker? ☐ YES ☐ NO Quit Date ____________

☐ NEVER a smoker

Do you drink alcohol?

☐ YES, number of drinks per week ________ ☐ NO

Occupation ______________________

**Medications (Please include dosage)** ☐ Not Currently Taking Medications

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**Medication Allergies** (Please list other allergies below.) **LATEX ALLERGY?** ☐ Yes ☐ No ☐ No Known Drug Allergies

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**REVIEW OF SYSTEMS -** Are you __currently__ having any of the following problems? **(Please check)**

**Eyes**
- ☐ Dry or itchy eyes
- ☐ Decreased vision

**Ears**
- ☐ Ringing or noise in the ears
- ☐ Ear pain or drainage
- ☐ Hearing loss

**Nose**
- ☐ Blocked or runny nose
- ☐ Loss of smell
- ☐ Nose bleeds

**Throat**
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Hoarse/Rough voice
- ☐ Frequent throat-clearing

**Heart**
- ☐ Chest pain with activity
- ☐ Irregular heartbeat

**Lungs**
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma

**Stomach**
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea or vomiting
- ☐ Bloody stools

**Bones and Muscle**
- ☐ Arthritis
- ☐ Muscle pain

**Skin**
- ☐ Changes in mole or wart
- ☐ New skin growth

**Neuro**
- ☐ Change in facial muscle strength
- ☐ Loss of facial sensation
- ☐ Headaches

**Allergy/Immuno**
- ☐ Seasonal allergies

**General**
- ☐ Fever greater than 99 degrees
- ☐ Unexplained weight loss
- ☐ Fatigue/Weakness