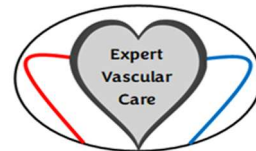


Medical History Record



DATE: _____

PATIENT NAME: _____ DOB: _____

CELL PHONE NUMBER: _____ HOME PHONE NUMBER: _____

HOME ADDRESS: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER: _____ FAX: _____

PREFERRED PHARMACY: _____

REASON FOR VISIT: _____

LIST OF MEDICATIONS OR ATTACH LIST:

Medical History Record

Have you previously been diagnosed with any of the following?

☐

BLOOD CLOTS IN LEGS

☐

DIABETES / RECENT A1C _____

☐

CHEST PAIN

☐

HYPERTENSION

☐

HEART ATTACK

☐

HIGH CHOLESTROL

☐

STROKE

☐

CANCER

☐

HEART DISEASE

☐

EMPHYSEMA/COPD

☐

KIDNEY DISEASE

☐

HEPATITIS

☐

LIVER DISEASE

☐

HIV/AIDS

Please List Any Allergies to Medications: _____

Please list any previous surgical procedures, including the kind of surgery and year

Height: _____ feet _____ inches Weight: _____ lbs

Have you ever used tobacco? Y / N How much? _____ How many years? _____

Quit Date: _____

Do you drink alcohol? Y / N How much? _____

Do you drink caffeine? Y / N How much? _____

Medical History Record

Please Circle any Symptoms you are Currently Experiencing:

Abdominal Pain	History of Gout	Ulcerations in Feet
Change in Bowel Habits	Joint Stiffness	Painful Extremities
Blood in stool	Leg Cramps	Claudication
Diarrhea	Leg Swelling	Cyanosis
Nausea	Muscle Spasms	Difficulty Laying Flat
Vomiting	Sciatica	Dyspnea on Exertion
Weight Loss	Balance Difficulty	Irregular Heartbeat
Weight Gain	Difficulty Speaking	Chest Pain
Weakness	Fainting	Cough
Fatigue	Gait Abnormality	Hemoptysis
Pain / Location _____	Headaches	Shortness of Breath
Blood in Urine	Loss of Strength	Sputum Production
Difficulty Urinating	Tingling/Numbing	Ulcerations
Poor Urine Output	Blanching of Skin	Skin Cancer
Painful Urination	Cold Extremities	Nail Changes
Arthritis	Decreased Sensation in Legs	
Back Pain	Pain in Legs with Exertion	

FAMILY MEDICAL HISTORY

Please Check the family member who has or has had the following:

Family Member	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer
Father					
Mother					
Brother					
Sister					

Do you have a living will?

Do you have a healthcare surrogate? Y / N

Name: _____

Contact Phone Number: _____