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
- ☐ CHEST PAIN
- ☐ HEART ATTACK
- ☐ STROKE
- ☐ HEART DISEASE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ DIABETES / RECENT A1C _____
- ☐ HYPERTENSION
- ☐ HIGH CHOLESTROL
- ☐ CANCER
- ☐ EMPHYSEMA/COPD
- ☐ HEPATITIS
- ☐ 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
Change in Bowel Habits
Blood in stool
Diarrhea
Nausea
Vomiting
Weight Loss
Weight Gain
Weakness
Fatigue
Pain / Location _____
Blood in Urine
Difficulty Urinating
Poor Urine Output
Painful Urination
Arthritis
Back Pain
History of Gout
Joint Stiffness
Leg Cramps
Leg Swelling
Muscle Spasms
Sciatica
Balance Difficulty
Difficulty Speaking
Fainting
Gait Abnormality
Headaches
Loss of Strength
Tingling/Numbing
Blanching of Skin
Cold Extremities
Decreased Sensation in Legs
Pain in Legs with Exertion
Ulcerations in Feet
Painful Extremities
Claudication
Cyanosis
Difficulty Laying Flat
Dyspnea on Exertion
Irregular Heartbeat
Chest Pain
Cough
Hemoptysis
Shortness of Breath
Sputum Production
Ulcerations
Skin Cancer
Nail Changes

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: _____