



## MEDICAL AND SURGICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Referring Physician (if any) \_\_\_\_\_  
Today's Date: \_\_\_\_\_ Reason for today's visit? \_\_\_\_\_  
How long have you had this problem? \_\_\_\_\_  
Is your problem related to an accident? Yes  No  Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_  
What medications or tests have you received for this problem in the past year? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY:**  
List all medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
List all surgeries: \_\_\_\_\_  
\_\_\_\_\_  
Please list your daily medications: (with strengths and dosage) \_\_\_\_\_  
\_\_\_\_\_  
Please list all *medications* you are allergic to: \_\_\_\_\_  
\_\_\_\_\_  
Please list any food or environmental *allergies*: \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**  
Do you currently smoke tobacco? \_\_\_\_\_ Packs/day? \_\_\_\_\_ Have you ever smoked tobacco? \_\_\_\_\_  
Do you use smokeless tobacco? \_\_\_\_\_ Packs/day? \_\_\_\_\_  
Do you drink alcohol or beer? \_\_\_\_\_ Amount per week? \_\_\_\_\_  
Occupation? \_\_\_\_\_ If patient is a child, does child attend daycare? \_\_\_\_\_  
Number of children in classroom? \_\_\_\_\_ Do any caregivers smoke? \_\_\_\_\_

**FAMILY HISTORY:**  
Please list any illnesses which run in your family. Include bleeding disorders, or bad reactions during surgery. \_\_\_\_\_  
\_\_\_\_\_  
Other information you would like the doctor to know: \_\_\_\_\_  
\_\_\_\_\_

Patient's name \_\_\_\_\_ Today's date \_\_\_\_\_

Do you have OR have you had problems with the following?

<b>GENERAL</b>	<b>YES</b>	<b>NO</b>
1. Chills	<input type="checkbox"/>	<input type="checkbox"/>
2. Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
3. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
4. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>EARS</b>	<b>YES</b>	<b>NO</b>
1. Hearing loss-gradual	<input type="checkbox"/>	<input type="checkbox"/>
2. Hearing loss-sudden	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain	<input type="checkbox"/>	<input type="checkbox"/>
4. Ringing	<input type="checkbox"/>	<input type="checkbox"/>
5. Dizziness or vertigo	<input type="checkbox"/>	<input type="checkbox"/>
6. Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>
7. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>NOSE</b>	<b>YES</b>	<b>NO</b>
1. Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
2. Injury	<input type="checkbox"/>	<input type="checkbox"/>
3. Congestion	<input type="checkbox"/>	<input type="checkbox"/>
4. Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
5. Mouth breather	<input type="checkbox"/>	<input type="checkbox"/>
6. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>THROAT</b>	<b>YES</b>	<b>NO</b>
1. Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>
2. Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
3. Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
4. Foreign body	<input type="checkbox"/>	<input type="checkbox"/>
5. Swollen tonsils	<input type="checkbox"/>	<input type="checkbox"/>
6. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>EYES</b>	<b>YES</b>	<b>NO</b>
1. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
2. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
3. Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>
4. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>HEART</b>	<b>YES</b>	<b>NO</b>
1. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
3. Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
4. Previous heart attack	<input type="checkbox"/>	<input type="checkbox"/>
5. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>LUNGS</b>	<b>YES</b>	<b>NO</b>
1. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
2. Asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/>
3. Congestion	<input type="checkbox"/>	<input type="checkbox"/>
4. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>GASTROINTESTINAL</b>	<b>YES</b>	<b>NO</b>
1. Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
3. Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
4. Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
5. Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
6. Nausea & vomiting	<input type="checkbox"/>	<input type="checkbox"/>
7. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>URINARY TRACT</b>	<b>YES</b>	<b>NO</b>
1. Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
3. Bloody urination	<input type="checkbox"/>	<input type="checkbox"/>
4. Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>MUSCULOSKELETAL</b>	<b>YES</b>	<b>NO</b>
1. Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
2. Weakness of limbs	<input type="checkbox"/>	<input type="checkbox"/>
3. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
4. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>NEUROLOGICAL</b>	<b>YES</b>	<b>NO</b>
1. Numbness	<input type="checkbox"/>	<input type="checkbox"/>
2. Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
4. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
5. Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
6. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>ENDOCRINE</b>	<b>YES</b>	<b>NO</b>
1. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
3. Menopause	<input type="checkbox"/>	<input type="checkbox"/>
4. Hormonal replacement	<input type="checkbox"/>	<input type="checkbox"/>
5. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
6. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>BLOOD DISORDERS</b>	<b>YES</b>	<b>NO</b>
1. Low blood counts	<input type="checkbox"/>	<input type="checkbox"/>
2. Free bleeding	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
4. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
5. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>ALLERGY/IMMUNE</b>	<b>YES</b>	<b>NO</b>
1. Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
2. Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
3. Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
4. Allergy testing in past	<input type="checkbox"/>	<input type="checkbox"/>
5. HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
6. Other _____	<input type="checkbox"/>	<input type="checkbox"/>