PATIENT HISTORY SHEET

DATE: _____________

NAME: ____ DATE OF BIRTH:_____________

STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) Number of children: _____________

MEDICAL HISTORY

#	Condition	YES	NO
1.	Headaches	☐	☐
2.	Eye Surgery	☐	☐
3.	Glasses/Contacts	☐	☐
4.	Glaucoma	☐	☐
5	Cataracts	☐	☐
6.	Tonsillitis	☐	☐
7.	Ear Tubes	☐	☐
8.	Ear Infections	☐	☐
9.	Frequent “Colds”	☐	☐
10.	Asthma or Emphysema	☐	☐
11.	Chronic Cough	☐	☐
12.	Pneumonia	☐	☐
13.	Lung Disease	☐	☐
14.	Tuberculosis	☐	☐
15.	Shortness of Breath	☐	☐
16.	Heart Disease	☐	☐
17.	Stroke	☐	☐
18.	High Blood Pressure	☐	☐
19.	Blood Clots	☐	☐
20.	Anemia or Blood Disease	☐	☐
21.	Cancer (location_______________)	☐	☐
22.	Back Disorder	☐	☐
23.	Gallbladder Disease	☐	☐
24.	Chronic Skin Rashes	☐	☐
25.	Thyroid Disorder	☐	☐
26.	Diabetes	☐	☐
27.	Stomach Pain	☐	☐
28.	Chronic Constipation	☐	☐
29.	Chronic Diarrhea	☐	☐
30.	Ulcers	☐	☐
31.	Colitis	☐	☐
32.	Change in Bowel Habits	☐	☐
33.	Black Tarry Stools	☐	☐
34.	Rectal Bleeding	☐	☐
35.	Hepatitis (liver)	☐	☐
36.	Kidney/Bladder Infections	☐	☐
37.	Kidney Stones	☐	☐
38.	Kidney Disease	☐	☐
39.	Blood in Urine	☐	☐
40.	Bedwetting over age 3	☐	☐
41.	Arthritis	☐	☐
42.	Gout	☐	☐
43.	Chronic Muscle Aches	☐	☐
44.	Venereal Disease	☐	☐
45.	Depression	☐	☐
46.	Seizure Disorder/Epilepsy	☐	☐
47.	Behavior Disorder	☐	☐
48.	Learning Disorder	☐	☐
49.	Emotional Disorder	☐	☐
50.	Other ________________________________		

Current Chronic Medical Problems: ____

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Past Accidents, Injuries, Hospitalizations and Surgeries: ____

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Current Medications with Doses: ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Other Physicians seen (past and present): ____

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ALLERGIES: ____

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Immunizations up to date? ☐ Yes ☐ No

ADULTS – Current Tetanus (last 10 years): ___________ Pneumovax: ___________ Influenza: _______________