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Medical History

Name ______________________________

Date ________________

Circle the appropiate item:

frequent ear infections	short of breath	fainting	diarrhea	stroke/seizure
hearing problems	asthma/wheezing	leg pain	constipation	tremors
ringing	chest pain	vericose veins	tar/blood in stool	sleeping difficulty
vision problems	heart problems	loss of appetite	hemorrhoids	anxiety
cataracts	high blood pressure	heartburn/reflux	hernia	depression
glaucoma	heart murmur	swallowing problems	urine infections	memory loss
sinus problems	rheumatic fever	ulcers	blood in urine	back pain
allergies/hay fever	irregular pulse	abdominal pain	urination frequency	foot pain
frequent sore throat	palpitations	hepatitis A,B,C	incontinence	arthritis
nose bleeds	high cholesterol	HIV	stones	breast disease
hoarsness	diabetes	gall bladder disease	vernereal disease	menstrual problems
pneumonia pleurisy	thyriod disease	pancreatitis	impotence	other:
chronic cough	swollen ankles	change in bowel habits	chronic fatigue	________________

street drug: Yes No Never

alcohol____per week

smoking____packs per day

exercise____times per week

Medications:

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Hospitalizations, surgeries, illness:

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Allergies:

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Family History:

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