

# MEDICAL HISTORY

PLEASE LIST ALL TIMES YOU HAVE BEEN HOSPITALIZED, GIVE DATES AND REASONS FOR HOSPITALIZATION(S):

\_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ALL OPERATIONS YOU HAVE HAD IF NOT DESCRIBED ABOVE AND GIVE DATES IF POSSIBLE:

\_\_\_\_\_

\_\_\_\_\_

ARE YOU ALLERGIC TO ANYTHING? (DRUGS, FOOD, ANIMALS) \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN RECENTLY:

\_\_\_\_\_

\_\_\_\_\_

DO YOU SMOKE?  YES  NO IF SO, HOW MANY PACKS/DAY? \_\_\_\_\_  
FOR APPROXIMATELY HOW LONG? \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO IF SO, WHAT AND HOW OFTEN PER WEEK? \_\_\_\_\_

## FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING?:

HEART DISEASE  STROKE  CANCER  DIABETES

HEREDITARY DISEASE  OTHER \_\_\_\_\_

=====

## PERSONAL HISTORY

PLEASE CIRCLE

**HEENT**

EXPLAIN

YES NO	EAR PROBLEMS _____
YES NO	SPELLS OF BLURRED VISION _____
YES NO	RECURRENT SORE THROATS _____
YES NO	PERSISTENT HOARSENESS _____
YES NO	DIFFICULTY SWALLOWING _____
YES NO	ENLARGED GLANDS _____
YES NO	THYROID PROBLEMS _____
YES NO	SINUS PROBLEMS _____
YES NO	GLAUCOMA _____
YES NO	CATARACTS _____
YES NO	FREQUENT HEADACHES _____
YES NO	DIZZINESS _____
YES NO	OTHER EYE PROBLEMS _____

## **PULMONARY**

YES NO	COUGH UP BLOOD _____
YES NO	DO YOU COUGH UP MUCOUS? IF SO, WHAT? _____
YES NO	CHRONIC COUGH _____
YES NO	CHEST PAIN _____
YES NO	ANY CHRONIC LUNG DISEASE? EMPHYSEMA, BRONCHITIS OR ASTHMA? _____
YES NO	SHORTNESS OF BREATH _____

## **MUSCULOSKELETAL**

YES NO	BACK OR NECK PAIN _____
YES NO	ARTHRITIS _____
YES NO	BROKEN BONES _____