MEDICAL HISTORY

Name: _____ Date of Birth:_____ Today's Date: _____

Do you have problems with or are being treated for: (Circle all that apply):

General: None □
Cancer (Type:_____)
(Status:_____)
Females: Currently Pregnant

Gastrointestinal: None □
Ulcer
Reflux

Endocrine: None □
Hyperthyroidism
Hypothyroidism
Diabetic Type I or II
(year diagnosed_____)

Skin: None □
Eczema/Rosacea

Genitourinary: None □
Prostate
Incontinence

Eyes: None □
Cataract/Glaucoma
Bell's Palsy
Eye Injury
Describe:_____
Iritis
Macular Degeneration

Ears/Nose/Throat/Mouth:
None: □
Chronic Sinus or Allergies
Hearing Loss

Pulmonary: None □
Asthma
Emphysema
COPD
Oxygen
Sleep Apnea
Chronic Bronchitis

Cardiovascular: None: □
Murmur
Palpitations
High Blood Pressure

Neurological: None □
Seizures: (When:_____)
Paralysis
Stroke
Head Injury
Multiple Sclerosis

Musculoskeletal:
None: □
Osteoporosis
Arthritis

Hematological: None: □
Anemia
Hepatitis A B C
Cholesterol

Immunologic: None □
Sjogrens syndrome
Lupus
Rheumatoid Arthritis
HIV/AIDS

Other Conditions not mentioned above: _____
Tobacco Use: _____ Current _____Former _____Never Type:_____
Amount per day:_____ Number of Years Used:_____
Ever tried to quit:_____ Quit Date: _____
Height: _____ Weight: _____
Medical Doctor (PCP):_____
Pharmacy:_____

Circle all that apply:

Alcohol Use:	Never	Rarely	Moderate	Daily	
Dentures:	Yes or No	Full or Partial	Upper	Lower	Both
Hearing Aids:	Yes or No	Right Ear	Left Ear	Both	

Family History: M=Mother F=Father S=Siblings

Disease	Yes	No		Disease	Yes	No	
Glaucoma				Cataracts			
Cancer				Arthritis			
Heart				Diabetes			
Hypertension				Kidney			
Lupus				Stroke			
Thyroid				Other			

(OVER)

Medications:

(BRING ALL MEDICATIONS, INCLUDING OVER THE COUNTER MEDS TO YOUR APPOINTMENT)

Name	Strength	How often	Reason For Taking

*****ARE YOU CURRENTLY TAKING OR HAVE YOU EVER TAKEN FLOMAX? YES or NO**

*****WHO PRESCRIBED THIS**: _____

Surgical History:

Surgery	Date

Allergies to Medications/Biologicals/Materials:

Patient is Allergic to:	Type of Reaction	When

office use only below this line

Date: _____ Rev. by: _____ AOTP? YES / NO Date: _____ Rev by: _____ AOTP? YES / NO

Date: _____ Rev. by: _____ AOTP? YES / NO Date: _____ Rev by: _____ AOTP? YES / NO

Date: _____ Rev. by: _____ AOTP? YES / NO Date: _____ Rev by: _____ AOTP? YES / NO