

PATIENT HISTORY SHEET

DATE: _____

NAME: _____ DATE OF BIRTH: _____

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

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

Current Chronic Medical Problems: _____

Past Accidents, Injuries, Hospitalizations and Surgeries: _____

Current Medications with Doses: _____

Other Physicians seen (past and present): _____

ALLERGIES: _____

Immunizations up to date? Yes No

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