Name: _____ Date: _____

PAST MEDICAL HISTORY

Please mark either **Yes** or **No** to indicate if any of the items listed below exist in your past medical history. Please briefly comment next to each item where **Yes** is marked.

	Yes	No	Comment
Abnormal chest x-ray			
Anesthesia complications			
Treatment for anxiety or depression			
Diagnosis of cancer			
Growth removed from the colon/rectum			
Sexually transmitted disease			
Heart attack			
Stroke or TIA (transient ischemic attack)			
Epileptic seizure			
Treatment for alcohol and/or drug abuse			
Tuberculosis or positive TB skin test			
Cosmetic or plastic surgery			

PREVENTIVE MEDICAL SCREENING

From the chart below, please mark either **Yes** or **No** indicate your clinical evaluations within the past year. Please indicate the reason for the test next to the item where **Yes** is marked.

	Yes	No	Comment
Urinary incontinence test			
Bone density test			
Bone Scan			
PET Scan			
Colonoscopy (lower GI with camera)			
Endoscopy (upper GI with camera)			
Fluoroscopy (Lower GI with barium)			
EMG (electromyography) (nerves)			
NCV (nerve conduction velocity)			
Myelogram (spine with dye injection)			
Brain Scan MRI			
Chest X-ray			
EKG (electrocardiogram) (heart)			
Cardiac Stress Test (on a treadmill)			
PFT (Pulmonary Function Test)			
Biopsy			
Mammogram (female)			
Digital Prostate Exam (male)			

Please indicate surgical operations you have had and the year of surgery. **None: ___**

Type of Surgery	Year Performed

Please indicate any metal or foreign material known to be inside your body. **None: ___**

Please indicate any bones that have been broken and the year it was broken. **None: ___**

Broken Bone	Date

Please indicate any medical conditions you have and name of treating physician. **None: ___**

MEDICATION ALLERGIES

Medication	Reaction

No known medication allergies: ____

CURRENT MEDICATIONS

List all prescription and over-the-counter medications that you <u>currently take</u>.

Medication Name	Dosage – Times Per Day	Purpose

(Please use back of form if additional space is needed.)

I currently take no medications: ____

REVIEW OF SYSTEMS

This is a confidential history for the purpose of reviewing your body systems. Please mark either **Yes** or **No** to indicate the medical symptoms **you are or are not** experiencing. Briefly **comment when Yes is marked**. Use common sense. *For example, insomnia once last month probably is not that important and would be marked no. However, insomnia 1-2 times per week is important and would be marked yes.*

	Yes	No	Comment
Constitutional:			
Recent weight change?			
Weakness?			
Fatigue?			
Chills?			
Eyes:			
Difficulty seeing?			
Do you wear glasses?			
Do you wear contacts?			
Ears, Nose, Throat:			
Problems with hearing?			
Nosebleeds?			
Congestion?			
Dentures or removable dental work?			
Hoarseness?			
Sore throat?			
Trouble swallowing?			
Teeth clenching?			
Jaw popping?			
Jaw locking?			
Respiratory:			
Difficulty breathing?			
Chronic cough?			
Emphysema?			
COPD?			
Asthma?			
Cardiovascular:			
Chest pain?			
Irregular rhythm?			
Leaky valves?			
Swollen ankles?			
Gastrointestinal:			
Heartburn?			
Indigestion?			
Constipation?			
Nausea?			
Vomiting?			

	Yes	No	Comment
Genitourinary:			
Frequent nighttime urination?			
Frequent bladder infections?			
Incontinence?			
Sexually transmitted diseases?			
Blood in urine?			
Genitourinary (Male):			
Enlarged prostate?			
Prostate cancer?			
Prostate cancer treatment?			
Prostate surgery?			
Genitourinary (Female):			
Possibility of pregnancy?			
Hysterectomy?			
Musculoskeletal:			
Recent traumatic incidents?			
History of implants?			
History of broken bones?			
Neurological:			
History of seizures?			
History of strokes?			
History of TIAs?			
Dizziness?			
Vertigo?			
Psychiatric:			
Anxiety?			
Depression?			
Hallucinations?			
Endocrine:			
History of low blood sugar?			
History of high blood sugar?			
Thyroid problems?			
Hematologic/Lymphatic:			
Anemia?			
HIV?			
Hepatitis?			
Allergic and Immunological:			
Allergies?			
Asthma?			
Allergy treatment?			

Patient Signature: _____ Date: _____