Patient Chart # (Office use only)	MEDICAL HISTORY	Date

Patient Name: Last	First	Middle	Maiden	Age	Date of Birth

Reason for Office Visit:

Referring Physician:	Primary Care Physician:

Drug Allergies and Reaction(s):

Medication	Reaction	Medication	Reaction

Current Medications/Dosage/Frequency:

Past Surgical Procedures:

Procedure	Date	Procedure	Date

Patient Medical History:

Diabetes	☐ Y ☐ N	Asthma/COPD	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Thyroid Disorder	☐ Y ☐ N
Heart Disease/Heart Attack	☐ Y ☐ N	Acid Reflux	☐ Y ☐ N
Stroke	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
Bleeding Disorder	☐ Y ☐ N	Kidney/Renal Disease	☐ Y ☐ N
Other medical problems:			

Family Medical History:

Bleeding Disorder	☐ Y ☐ N	Malignant Hyperthermia	☐ Y ☐ N
Other medical problems/conditions that run in your family:			

Food Allergies? ☐ Y ☐ N If yes, what type? _____

Animals in the house? ☐ Y ☐ N If yes, what kind? _____

Current/former smoker? (Age 13 & up) ☐ Y ☐ N How much? _____ When did you stop? _____

Smokeless Tobacco? ☐ Y ☐ N Frequency? _____ Alcohol? ☐ Y ☐ N Frequency? _____

Immunizations current? (up to age 21) ☐ Y ☐ N Last Flu shot: _____ Last pneumonia shot: _____

Last mammogram: _____ Last colonoscopy: _____

Pediatric Patients/Children (only):

Was the patient born premature? ☐ Y ☐ N If yes, # of weeks gestation? _____

Complications during pregnancy/labor? ☐ Y ☐ N If yes, what kind? _____

Does parent/guardian smoke or use tobacco? ☐ Y ☐ N If yes, what form? _____ Frequency? _____

Patient accompanied by: _____

Preferred pharmacy: _____

REVIEW OF SYSTEMS

Has the patient recently been diagnosed with or experienced any of the following conditions?

Constitutional

☐ Y ☐ N Unexplained weight gain or loss?

☐ Y ☐ N Fevers or chills?

Skin

☐ Y ☐ N Rash or skin disorder?

Eyes

☐ Y ☐ N Recent change in vision?

☐ Y ☐ N Redness or itching?

Ear, Nose & Throat

☐ Y ☐ N Loss or decline in hearing?

☐ Y ☐ N Problems breathing through the nose?

☐ Y ☐ N Sleep disorders?

Allergic/Immunologic

☐ Y ☐ N History of anaphylaxis or severe allergy?

☐ Y ☐ N History of allergy testing?

☐ Y ☐ N History of allergy shots?

☐ Y ☐ N Human Immunodeficiency Virus (HIV)?

Respiratory

☐ Y ☐ N Productive cough?

☐ Y ☐ N Asthma symptoms?

☐ Y ☐ N Emphysema/COPD?

Cardiac

☐ Y ☐ N Can you walk one mile without stopping?

☐ Y ☐ N Can you walk up two flights of stairs without stopping?

☐ Y ☐ N Angina or chest pain?

☐ Y ☐ N Rapid or irregular heart rhythm?

Gastrointestinal

☐ Y ☐ N Change in diet due to difficulty swallowing?

☐ Y ☐ N Pain with swallowing?

☐ Y ☐ N Heartburn or acid reflux?

☐ Y ☐ N Hepatitis?

Urinary/Renal

☐ Y ☐ N Poor kidney function?

☐ Y ☐ N Urinary tract problems?

Musculoskeletal?

☐ Y ☐ N Neck arthritis?

☐ Y ☐ N TMJ/Jaw joint problems?

Neurologic

☐ Y ☐ N Frequent headaches?

☐ Y ☐ N Migraines?

☐ Y ☐ N Seizures?

Hematologic/Lymphatic

☐ Y ☐ N Swollen lymph nodes?

☐ Y ☐ N Anemia/low blood counts?

☐ Y ☐ N Bruise easily or bleeding disorder?

Endocrine

☐ Y ☐ N Hyperthyroidism?

☐ Y ☐ N Hypothyroidism?

☐ Y ☐ N Uncontrolled or poorly controlled diabetes?

Psychiatric

☐ Y ☐ N Depression?

☐ Y ☐ N Anxiety attacks or panic disorder?