General Medical History

Patient Name: Date: Birth Date:

Primary Physician: Who Requested this Consultation?

Age: Height: Weight: Occupation: Handedness: R L Ambi

Current Medical Problems:

Surgical History:

Allergies:

Medications (Include Vitamins):

Do You Smoke? Y N How Much?

Drink? Y N How Much?

Illicit Drugs? Y N What kind and How much?

Vape? Y N How Much?

Family History: Diabetes Y N Heart Disease Y N Cancer Y N
Other:

Review of Systems:

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Sweats

Musculoskeletal
Pain, weakness, Numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genitourinary:
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal:
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting

Cardiovascular:
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Rapid heartbeat
- ☐ Poor Circulation
- ☐ Irregular heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye/Ear/Nose/ Throat:
- ☐ Bleeding gums
- ☐ Visual Problems
- ☐ Dry eye
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Loss of hearing

- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't Heal

Men Only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period _____

Date of last Pap Smear_____

Date of last mammogram _____

Are you currently pregnant?_____

Number of pregnancies _____

Number of Children _____

Conditions

- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Sexually Transmitted Disease

Any other medical problems:_____

Would you like to receive health information via email? _____

Email address _____

The medical history above is true and accurate to the best of my knowledge.

I have had the opportunity to review the privacy statement.

Signature_____Date_____

How may we contact you?

☐ Home phone May we leave a message with the person answering your home phone?_____

☐ Work phone May we leave a message on your answering machine?_____