

Initial Visit Medical History Form (p. 1): Please provide the following medical information to the best of your ability:

Date:	Age:	List any ALLERGIES TO MEDICATIONS:	
What problems are you here for today?			
Past Medical History:			
1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
Diabetes (Circle: type I / type II)	<input type="checkbox"/> <input type="checkbox"/>	Stomach or Intestinal problems	<input type="checkbox"/> <input type="checkbox"/>
Hypertension (high blood press)	<input type="checkbox"/> <input type="checkbox"/>	Allergy problems/therapy	<input type="checkbox"/> <input type="checkbox"/>
Thyroid problems	<input type="checkbox"/> <input type="checkbox"/>	Kidney problems	<input type="checkbox"/> <input type="checkbox"/>
Heart Disease/cholesterol probs	<input type="checkbox"/> <input type="checkbox"/>	Neurological problems	<input type="checkbox"/> <input type="checkbox"/>
Respiratory problems	<input type="checkbox"/> <input type="checkbox"/>	Cancer	<input type="checkbox"/> <input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>	Other Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/>
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):			
3) Please list any current medications (and amounts, times per day); <i>(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC meds including sinus/allergy/weight loss meds):</i>			
Social History:		Please list details below:	
Do you use tobacco?	<input type="checkbox"/> <input type="checkbox"/>	List type and how much:	
If no, did you use it previously?	<input type="checkbox"/> <input type="checkbox"/>	List type and how much:	When did you quit?
Do you use recreational drugs?	<input type="checkbox"/> <input type="checkbox"/>	List type and how much:	
Do you drink alcohol?	<input type="checkbox"/> <input type="checkbox"/>	List type and how much:	
What is your occupation?			
Family History:			
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:			
If yes, please indicate which relative(s) have the problem			
	<u>Yes</u> <u>No</u>		
Heart problems / murmurs	<input type="checkbox"/> <input type="checkbox"/>		
Allergy	<input type="checkbox"/> <input type="checkbox"/>		
Diabetes	<input type="checkbox"/> <input type="checkbox"/>		
Cancer	<input type="checkbox"/> <input type="checkbox"/>		
Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>		
Anesthesia problems	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> See attached dictation	Reviewed by:

