PATIENT MEDICAL HISTORY

Patient Name ____________________________ **Age** ____ **DOB** ___________ **Date of Visit**_________
Accompanied with: Mother Father Spouse Other__________________
Appointment Reminder Preference: Phone #__________________________________ **Call or Text**
Primary Care Physician:____

For Office Use: Chief Complaint:

Please list all daily medications (and dosages):

Med	Med	Med	**For Office Use: Room#**
Dosage:	Dosage:	Dosage:	**HT: inches WT: lbs**
Med	Med	Med	**cm kg**
Dosage:	Dosage:	Dosage:	**BP: HR:**
Med	Med	Med	**RESP:**
Dosage:	Dosage:	Dosage:	**SP02: RM Air O2**

Please list any medication allergies or negative reactions to medications, if known:
____

Please note if the patient has (or has had) significant problems with the following:

General
Weakness / Fatigue Y N
Fever (frequent or prolonged) Y N
Poor Weight Gain Y N
Vision Problems / Glasses Y N

HEENT
Nasal Congestion Y N
Hearing Problems Y N
Nosebleeds / Unusual Bleeding Y N
Sore Throat (unusual) Y N
Feeding Difficulties Y N
Swallowing Problems Y N
Head Injury Y N

Cardio/Vasc
Fast Heart rate Y N
Chest Pain Y N
Irreg. Heart rate Y N
Poor Exercise Capability Y N
Excessive Sweating Y N
Fainting Y N
Heart Murmur Y N
Known or Suspected Heart Defect Y N

GI
Diarrhea Y N
Constipation Y N
Nausea / Vomiting Y N
Stomach Pain Y N

GU
Bladder / Kidney Problems Y N

Musculoskeletal
Joint Pain / Swelling Y N
Back Pain / Muscle Pain Y N
Broken Bones Y N
Scoliosis Y N

Derm
Rash / Skin Problems Y N

Neurological
Seizures Y N
Headaches Y N

Endo/Metabolic
Excessive Thirst Y N
Unexplained Weight Loss / Gain Y N

Chest/Pulm
Cough Y N
Frequent Pneumonia Y N
Asthma Y N
Labored /Rapid Breathing Y N
Chest Trauma Y N

Other
School / Behavioral Problems Y N
Difficulties at Birth / Premature Birth Y N
Need for Supplemental Oxygen Y N
Difficulty with Travel to Mountains Y N

*If there are **NO** changes from **prior visits** in family medical history, or patient hospitalizations or surgeries, you may indicate by checking here □ and proceed to any "worries or concerns" you may have. If this is a first time visit, please complete the remainder of the form.*

Please note if any of the following exist in family members or close relatives (list the relatives):

Heart Attack / Heart Disease (CAD) before age 50 Y N ________________________________

High Blood Pressure (Hypertension) Y N ________________________________

High Cholesterol / Triglycerides Y N ________________________________

Birth Defects of the Heart (Congenital Heart Defects) Y N ________________________________

Sudden Death Y N ________________________________

Arrhythmia (Irregular Heart Rhythm) Y N ________________________________

Cardiomyopathy (Dilated or Hypertrophic) Y N ________________________________

Diabetes Y N ________________________________

Please list any other medical conditions the patient has:

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Does any household member, baby sitter, or patient smoke cigarettes? Y N __________________

Are immunizations current: Y N

Patient lives with … Mother Father Both Other____

Please list any Hospitalizations/Surgeries (Please give dates)

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Please list any specific worries or concerns that you may have about the patient's health:

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