PATIENT MEDICAL HISTORY

Patient Name ___________________________ **Age** ____ **DOB** ___________ **Date of Visit** _______

Please list all daily medications (and dosages):

Med	Med	Med	For Office Use: Room#
Dose	Dose	Dose	HT: WT:
Med	Med	Med	BP: HR:
Dose	Dose	Dose	RESP: SP02:

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

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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

Patient Name ___________________________________

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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