

# CONFIDENTIAL MEDICAL HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M D W Religion: \_\_\_\_\_

General Health: EXCELLENT / GOOD / FAIR / POOR Ethnic Background: \_\_\_\_\_

**HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING?  
(PLEASE MARK EACH AND EVERY INQUIRY)**

	YES	NO		YES	NO		YES	NO
Visual disturbances/eye problems			Extra heart beats/irregular pulse			Tarry/bloody stools		
Do you wear contacts?			Abnormal EKG			Hemorrhoids		
Glaucoma/eye disorder			Digitalis treatment (for heart)			Problem constipation		
Airway obstruction (nose)			Dropsy/heart failure			Vomiting blood		
Fracture of neck/spine			Rheumatic fever			Alcoholism		
Thyroid/Goiter problems			Heart murmurs/Mitral Valve Prolapse			Esophageal varices		
Breast cysts, tumors, abscesses			Bleeding Ulcers			Kidney/renal disease		
Nipple discharge			Other heart disorder/M.V.P.			Abnormal bleeding tendency		
Asthma			Stroke/Paralysis			Abnormal bleeding after tooth extraction		
Bronchitis			Blood pressure increase			Blood disorder		
Pneumonia			Cancer			Blood transfusion		
TB (Tuberculosis)			Diabetes			Skin disorders		
Emphysema			Nervous disorder			Arthritis		
Coughing blood			Nervous breakdown			Hay fever		
Smoker's cough			Hepatitis A,B, C, D			Major allergies		
Shortness of breath			Yellow jaundice			Palsy/paralysis		
Heart trouble/heart attack			Gallbladder problems			Insomnia		
Fainting			Cirrhosis of the liver			Drug habit		
Anemia			Frequent indigestion or bleeding ulcers			Self-destructive tendencies		
Irregular pulse/palpitation			Colitis			Psychiatric treatment		
Chest pain			AIDS, ARC or positive AIDS test			Psychiatric hospitalization		

1. Have you had a bad cold/influenza in the past month? YES / NO If so, when? \_\_\_\_\_ Are symptoms still present? YES / NO
2. Are you allergic to any medications, latex, food products, skin applications or any other substances? YES / NO Which? \_\_\_\_\_
3. Do you have any family history of cancer, heart trouble or stroke? YES / NO If so, who and which condition(s)? \_\_\_\_\_
4. Do you have cocktails regularly or consume beer, wine or other alcoholic beverages? YES / NO If so, what and how often? \_\_\_\_\_
5. Do you smoke or use any form of tobacco or nicotine (including Nicorette Gum or patches)? YES / NO If so, how much? \_\_\_\_\_
6. Is there a possibility that you are pregnant? YES / NO When was your last menstrual period? \_\_\_\_\_ Was it normal? YES / NO
7. Please list all present medications, including birth control pills, hormones vitamins, herbs and psychiatric medications and natural supplements that you take: \_\_\_\_\_
8. Have you ever been on cortisone/steroid treatment? YES / NO When? \_\_\_\_\_
9. Have you ever had cold sores, herpes, fever blisters or shingles? YES / NO If so, where and when? \_\_\_\_\_

(OVER)

(CONTINUED...)

10. Please list all surgical procedures, including date and reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Please list hospitalizations, including dates and reasons \_\_\_\_\_  
\_\_\_\_\_
12. How many pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_ Breastfed? \_\_\_\_\_ How long? \_\_\_\_\_
13. Previous mammogram? YES / NO When? \_\_\_\_\_ Where? \_\_\_\_\_
14. Have you ever been under psychiatric care? YES / NO When and by Whom? \_\_\_\_\_
15. When was your last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_
16. When was your last eye exam? \_\_\_\_\_ By whom? \_\_\_\_\_
17. When was your last chest x-ray and where? \_\_\_\_\_
18. How much and what kind of exercise do you do? \_\_\_\_\_
19. What is your maximum exercise? \_\_\_\_\_
20. Are you a vegetarian? YES / NO If so, for how long? \_\_\_\_\_
21. Do you use amphetamines, diet control pills, herbal stimulants like "Ephedra" or use cocaine or other stimulants? YES / NO  
If so, which? \_\_\_\_\_
22. Do you use mind-altering or "recreational" drugs, sedatives, tranquilizers or such substances such as marijuana, "ice," ecstasy, prescription  
pain medications, sleeping pills, sedatives or tranquilizers? YES / NO If so, which and how much? \_\_\_\_\_  
\_\_\_\_\_
23. Have you used any erectile enhancement medications such as "Viagra," "Cialis" or "LaVetra"? If so, when and which? \_\_\_\_\_  
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**PATIENT SIGNATURE**

COMMENTS BY DOCTOR: