

Name Patient's: _____ Chart Number: _____

Past Medical History

Have you or members of your family ever been told that any of you have:

	You	Your Family	Describe
Anemia	[]	[]	_____
Asthma	[]	[]	_____
Abnormal Bleeding	[]	[]	_____
Blood clots / phlebitis	[]	[]	_____
Cancer / tumor	[]	[]	_____
Diabetes	[]	[]	_____
Drug abuse	[]	[]	_____
Eczema / psoriasis	[]	[]	_____
Epilepsy / seizures	[]	[]	_____
Heart Condition	[]	[]	_____
High Cholesterol	[]	[]	_____
HIV	[]	[]	_____
High or low blood pressure	[]	[]	_____
Liver disease / yellow jaundice	[]	[]	_____
Hepatitis A B C	[]	[]	_____
Kidney / bladder problems	[]	[]	_____
Lung disease	[]	[]	_____
Prostate problems	[]	[]	_____
Stroke	[]	[]	_____
Thyroid disease	[]	[]	_____
Tuberculosis	[]	[]	_____
Ulcer in stomach / duodenum	[]	[]	_____
Osteoporosis	[]	[]	_____
Arthritis	[]	[]	_____
Other bone / joint disease	[]	[]	_____
Any nervous system disease	[]	[]	_____

Rev. 01/12/09

The above information is true and correct to the best of my belief.

Patient signature _____ Date _____

Name Patient's: _____ Chart Number: _____

Have you ever had:

- | | | | |
|----|---|----------|-----------|
| 1 | Heartburn or indigestion? | No _____ | Yes _____ |
| 2 | Bowel movements that were bloody or tarry? | No _____ | Yes _____ |
| 3 | Any recent change in your bowel habits? | No _____ | Yes _____ |
| 4 | Frequent urination during the day or night? | No _____ | Yes _____ |
| 5 | Any recent loss of control of your bladder? | No _____ | Yes _____ |
| 6 | Burning with urination? | No _____ | Yes _____ |
| 7 | Difficulty starting your urination? | No _____ | Yes _____ |
| 8 | Excessive urination? | No _____ | Yes _____ |
| 9 | Excessive thirst? | No _____ | Yes _____ |
| 10 | Shortness of breath or wheezing? | No _____ | Yes _____ |
| 11 | Chronic cough? | No _____ | Yes _____ |
| 12 | Chest pain with activity? | No _____ | Yes _____ |
| 13 | Racing heart or palpitations? | No _____ | Yes _____ |
| 14 | Swollen feet or ankles? | No _____ | Yes _____ |
| 15 | Frequent headaches? | No _____ | Yes _____ |
| 16 | Difficulty hearing? | No _____ | Yes _____ |
| 17 | Dental or other mouth problems? | No _____ | Yes _____ |
| 18 | Frequent nose bleeds? | No _____ | Yes _____ |
| 19 | Easy bruising? | No _____ | Yes _____ |
| 20 | Skin rashes? | No _____ | Yes _____ |
| 21 | Aching muscles or joints? | No _____ | Yes _____ |
| 22 | Swollen joints? | No _____ | Yes _____ |
| 23 | Cold hands / feet? | No _____ | Yes _____ |
| 24 | Gangrene? | No _____ | Yes _____ |
| 25 | Loss of consciousness? | No _____ | Yes _____ |
| 26 | Recent numbness in arms or legs? | No _____ | Yes _____ |
| 27 | Chronic fatigue? | No _____ | Yes _____ |
| 28 | Uncontrolled bleeding? | No _____ | Yes _____ |
| 29 | Weight loss? | No _____ | Yes _____ |
| 30 | Weight gain? | No _____ | Yes _____ |
| 31 | Heat / cold intolerance? | No _____ | Yes _____ |

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Patient signature _____ Date _____

