

# MEDICAL RECORD

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you or a family member been seen in the office before?

Yes

No

If yes, please list the name of the person and their relationship to you: \_\_\_\_\_

What brings you to our office today? \_\_\_\_\_

When did the problem start? \_\_\_\_\_

Have you consulted another physician for this or other related problems?  Yes

No

## PAST MEDICAL HISTORY

General Health:  Excellent

Good

Fair

Poor

Please describe any current health problems: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight loss/gain in past year? \_\_\_\_\_

Date of last medical exam: \_\_\_\_\_ Doctor's name: \_\_\_\_\_

EKG?  Yes  No

Chest X-Ray?  Yes  No

Lab Tests?  Yes  No

Please list all medications you are presently taking and the dose (mg.):

Name: \_\_\_\_\_ Dose/Frequency: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications to which you are allergic and please give the reaction:

Previous surgery?  Yes  No

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

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

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

Did you have complications following surgery?  Yes  No If yes, please explain: \_\_\_\_\_

Have you or a family member had complications with local or general anesthesia?  Yes  No

If yes, please explain: \_\_\_\_\_

Please list any prior injuries:

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

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

Hospitalizations not shown above:

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

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