PRE-HISTORY INFORMATION

Name: _____ **Date**: _____
Date of Birth: _____ **Age**: _____ **Referred By**: _____

1. **State in your own words the major medical reason(s) for coming in today:**
   _____
   _____
   _____.
2. **Please list all medications that you use. Please bring these with you:**
   _____
   _____.
3. **Drug Allergies? None: _____ If yes, please list: _____.**
4. **Family History: please indicate the health or cause of death of members of your family as best as you can:**

	Age if Living	Age at Death	Indicate any serious diseases	Cause of death
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				
Other				

Please indicate which of your relatives has any of the following diseases:
Cancer: _____ Diabetes: _____
Heart Problems: _____ High Blood Pressure:_____
Kidney Disease: _____ Mental/Emotional Problems: _____
Stroke: _____ Tuberculosis: _____
Arthritis: _____ Other: _____

5. **Menstrual History**

Number of pregnancies	
Number of live births	
Last menstrual period	
Age at menopause	

6. **Please indicate by checking yes or no if you have had significant problems in the below areas. Please comment on special problems and indicate approximate dates:**

Yes	No	Nature of Problem	Comment/Approximate Dates
		Recent weight loss	
		Headaches	
		Trouble with vision	
		Trouble with hearing	

Yes	No	Nature of problem	Comment/Approximate Dates
		Allergic Reaction to medications? Name:	
		Allergies: Hay Fever? Asthma?	
		Thyroid (Goiter)	
		Diabetes	
		Skin Problems	
		Anemia or Abnormal Bleeding	
		Heart Problems	
		Circulation Problems	
		High Blood Pressure	
		Chest Pain	
		Lung Problems (Pneumonia, TB, etc….)	
		Shortness of breath, coughing, pleurisy, wheezing	
		Liver Disease, Gallbladder disease, Jaundice	
		Stomach problems: Ulcers, indigestion, change in bowels, constipation, diarrhea	
		Abdominal Pain	
		Kidney disease or stones	
		Urination Problems	
		Female organs	
		Joint Pain or Stiffness	
		Phlebitis	
		Do you smoke? How much?	
		Do you drink alcoholic beverages? How much?	
		Coffee? How much?	
		Depression	
		Nerves, difficulty sleeping	
		Psychiatric	
		Fainting or convulsion	
		Stroke	
		Pain in other areas	
		Other Illness or problems	

7. Please give details of any of the following:

	Approximate Dates	Surgeon	Hospital
Operations:			
Serious Injuries:			

PLEASE BE SURE THAT YOU HAVE FILLED OUT BOTH PAGES OF THIS FORM!

Please feel free to attach any other recorded information, which you feel, will be of importance to the doctor in evaluating your health problems.