NAME: ____ DATE: ______________________

PAST & PRESENT MEDICAL HISTORY

(Please mark all that applies with an X. Include diseases you are currently taking medicine for.)

_____ Allergies
_____ Anemia
_____ Aneurysm
_____ Arthritis
_____ Asthma
_____ Cancer _____________________
_____ Cerebropalsy
_____ Cirrhosis
_____ Coagulation Disorder
_____ Congestive Heart Failure
_____ Chronic Lung Disease
_____ Coronary Artery Disease
_____ Diabetes
_____ Diverticulosis
_____ Emphysema
_____ Gastro Esophageal Reflux Disease
_____ Glaucoma
_____ Headaches
_____ HIV Positive
_____ AIDS
_____ Hypercholesterolemia
_____ Hypertension (high blood pressure)
_____ Hyperthyroidism
_____ Hypothyroidism
_____ Kidney Stones
_____ Kidney Failure
_____ Liver Failure
_____ Macular Degeneration
_____ Meningitis
_____ Mitral Valve Prolapse
_____ Multiple Sclerosis
_____ Myocardial Infarction
_____ Osteoporosis
_____ Parkinson’s
_____ Phlebitis
_____ Pneumonia
_____ Prostatitis
_____ Pulmonary Emboli
_____ Rheumatic Fever
_____ Seizure Disorder
_____ Sickle Cell
_____ SLE (Lupus)
_____ Sleep Apnea
_____ Stroke
_____ TB
_____ Ulcers
_____ Urinary Tract Infections
_____ Valvular Disease
_____ Other ______________________
____
____

PAST SURGICAL HISTORY

_____ Adenoidectomy
_____ Aneurysm Repair
_____ Appendectomy
_____ Breast Biopsy
_____ Cardiac Pacemaker/Defibrillator
_____ Cardiac Surgery
_____ Carotid Endarterectomy
_____ Carpal Tunnel Release
_____ Cataract Surgery
_____ Colectomy
_____ Endoscopic Sinus Surgery
_____ Hemorrhoidectomy
_____ Herniorrhaphy
_____ Hip Replacement
_____ Hysterectomy
_____ Knee Arthroscopy
_____ Knee Replacement
_____ Laparoscopy
_____ Lumpectomy
_____ Mastectomy
_____ Myringotomy & Tubes
_____ Nephrectomy
_____ Oral Surgery
_____ Peripheral Vascular Revascularization
_____ Prostate Surgery _______________
_____ Repair of Fracture
_____ Septoplasty
_____ Spine Surgery
_____ Thyroidectomy
_____ Tonsillectomy/Adenoidectomy
_____ Tubal Ligation
_____ Turbinectomy
_____ Tympanoplasty
_____ Tympanoplasty/Mastoidectomy
_____ UPPP
_____ Other: _______________________
____
____

REVIEW OF SYSTEMS

(Please mark all that applies with an X.)

I. GENERAL
______ Appetite loss
______ Fatigue
______ Fever
______ Weight loss

II. SKIN
______ Change in wart/mole
______ Dryness
______ Itching
______ Rash

III. EARS/NOSE/MOUTH/THROAT
______ Eye pain
______ Visual disturbances
______ Hearing loss
______ Ear discharge
______ Ear pain
______ Ringing in the ears
______ Nosebleeds
______ Nasal congestion
______ Sleep apnea
______ Snoring
______ Hoarseness
______ Sore throat

IV. NECK
______ Neck mass
______ Neck pain
______ Neck stiffness

V. RESPIRATORY
______ Chronic cough
______ Difficulty breathing
______ Wheezing

VI. CARDIOVASCULAR
______ Chest pain
______ Elevated blood pressure
______ Palpitations
______ Shortness of breath

VII. GI
______ Abdominal pain
______ Bloody stool
______ Change in bowel habits
______ Difficulty swallowing
______ Indigestion
______ Vomiting

VIII. GU
______ Change in bladder habits
______ Discharge
______ Painful urination
______ Urgency

IX. MUSCULOSKELETAL
______ Decreased range of motion
______ Joint pain
______ Muscle pain
______ Muscle weakness

X. NEUROLOGICAL
______ Attention deficit
______ Dizziness
______ Headaches
______ Incoordination
______ Tremors

XI. PSYCHIATRIC
______ Anxiety
______ Depression
______ Inability to concentrate
______ Memory loss

XII. ENDOCRINE
______ Cold intolerance
______ Excessive thirst
______ Excessive urination

XIII. HEMATOLOGY
______ Easy bruising
______ Enlarged lymph nodes
______ Excessive bleeding

FAMILY HISTORY

If any **BLOOD RELATIVE** has had any of the following please indicate the relationship to you next to the condition.
(Be sure to mention if the relative is on your mother's or father's side of the family.)

Condition	Relationship	Condition	Relationship
Alcoholism		Diabetes	
Allergies		Emphysema	
Arthritis		Heart Disease	
Asthma		Hypercholesterolemia	
Bipolar Disorder		Hypertension	
Cancer		Hypoglycemia	
Cerebrovascular Accident		Kidney Disease	
Chronic Bronchitis		Malignant Hyperthermia	
Coagulation Disorder		Osteoporosis	
Congestive Heart Failure		Parkinson's Disease	
Chronic Lung Disease		Seizure Disorder	

DEMOGRAPHICS
(Please circle all that apply)

Race: American Indian or Alaska Native Asian Black or African American More than one race
Native Hawaiian Other Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Language: ____________________________

Birthplace: ____________________________

SOCIAL HISTORY
(Please circle all that apply)

Tobacco Use: None Cigarettes Chew Cigars Pipe Dip
How Much: ____

Previous Tobacco Use: None Cigarettes Cigars Pipe Dip
Other: ______________ How Much________ How Long_______ Date Quit_______

Alcohol Use: None Minimal Moderate Heavy Previous user Seldom/Rare

Caffeine Use: None Minimal Moderate Large

Pets in home: None Dog(s) Cat(s) Other(s) _________________________

RX HISTORY
(Please fill out)

Current Medications (include name, strength, and dosage information): ___________________________

____

____

____

Drug Allergies: ____

____

____

____ _________________________
Patient Signature Date

Thank you,

James B. Maddox, MD