

NAME: _____ DATE: _____

PAST & PRESENT MEDICAL HISTORY

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

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

PAST SURGICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Colectomy |
| <input type="checkbox"/> Endoscopic Sinus Surgery | <input type="checkbox"/> Hemorrhoidectomy |
| <input type="checkbox"/> Myringotomy & Tubes | <input type="checkbox"/> Herniorrhaphy |
| <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Repair of Fracture | <input type="checkbox"/> Knee Arthroscopy |
| <input type="checkbox"/> Septoplasty | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Tonsillectomy/Adenoidectomy | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Turbinectomy | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Tympanoplasty | <input type="checkbox"/> Nephrectomy |
| <input type="checkbox"/> Tympanoplasty/Mastoidectomy | <input type="checkbox"/> Cardiac Pacemaker/Defibrillator |
| <input type="checkbox"/> UPPP | <input type="checkbox"/> Peripheral Vascular Revascularization |
| <input type="checkbox"/> Aneurysm Repair | <input type="checkbox"/> Prostate Surgery _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Carpal Tunnel Release | _____ |
| <input type="checkbox"/> Cataract Surgery | _____ |

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 mark with an X.

- | | |
|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Cerebrovascular Accident | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> Coagulation Disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Seizure Disorder |

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