SHORT MEDICAL HISTORY

NAME_____
DATE_____AGE_____

I. PRESENT ILLNESS (WHY ARE YOU SEEING THE DOCTOR?):_____

II. OTHER MEDICAL HISTORY:

A. What other problems are you being treated for by any other doctor?_____

B. List all current medications: | Strength | Dosage

C. List ALLERGIES to medications:_____

E. List all surgeries you have had (list year or age):TONSILLECTOMY?_____ADENOIDS?_____
OTHERS?_____

III. Do you or any BLOOD RELATIVES have:

	(YES) Relation		(YES) Relation
high blood pressure	( )	diabetes	( )
heart disease	( )	thyroid problem	( )
stroke	( )	kidney disease	( )
lung problems	( )	obesity	( )
cancer of?_____	( )	other?_____	( )

IV. SOCIAL HISTORY:

A. Do you smoke or chew tobacco? Yes___ How much daily?_____How long?_____
No____ Did you in the past? If so, how much?_____How long?_____
When did you quit?_____

B. Were/are your parents smokers? Mother:Yes_____ No_____ Father:Yes_____ No_____

C. Do you use alcohol? Yes__ How much daily?_____ orweekly_____How long?_____
No____ Did you in the past? If so, how much?_____How long?_____
When did you quit?_____

D. Have you had problems with alcohol or drug abuse? Yes____ No____

E. What is your occupation?_____

V. GENERAL HEALTH:

A. Present height:_____ weight:_____
If you are an adult, has your weight been stable? Yes_____ No_____