PHYSICAL AND AESTHETIC MEDICINE

MEDICAL HISTORY

Patient Name_____ Age _____ DOB: _____
Referring Physician _____Family Physician _____

What is the main problem that brought you to the doctor today? _____
_____
_____
Have you had any tests? _____
Have you had any treatment? _____

MEDICAL HISTORY (date started):

- □ Headaches _____
- □ Stroke _____
- □ Seizures _____
- □ Pneumonia _____
- □ Diabetes _____
- □ Thyroid Disease _____
- □ Vision Loss _____
- □ Hearing Loss _____
- □ High Blood Pressure _____
- □ Blood Clots _____
- □ Heartburn _____
- □ Stomach Disease/Ulcers_____
- □ Heart Disease _____
- □ High Cholesterol _____
- □ Liver Disease _____
- □ HIV/AIDS _____
- □ Chronic Back Pain _____
- □ Multiple Sclerosis _____
- □ Broken Bones/Fractures _____
- □ Other _____
- □ Cancer _____
- □ Sleep Apnea _____
- □ Kidney Stones _____
- □ Lung Disease _____
- □ Asthma _____
- □ Depression _____
- □ Bipolar Disorder _____
- □ Anxiety _____
- □ Fibromyalgia _____
- □ Chronic Fatigue Syndrome _____
- □ Arthritis _____
- □ Gout _____
- □ Osteoporosis _____
- □ Prostate Disease _____
- □ Breast Disease _____
- □ Erectile Dysfunction _____
- □ Brain Injury _____
- □ MRSA/VRE _____
- □ Polio _____

SURGICAL HISTORY (indicate date if known):

- □ None
- □ Cataracts _____
- □ LASIK _____
- □ Tonsillectomy _____
- □ Thyroidectomy _____
- □ Adenoidectomy _____
- □ Coronary Bypass _____
- □ Cardiac Stents _____
- □ Pacemaker/Defibrillator_____
- □ Heart Valve _____
- □ Gall Bladder _____
- □ Appendectomy _____
- □ Bowel/Stomach Resection _____
- □ Hemorrhoidectomy _____
- □ Bariatric surgery _____
- □ Hysterectomy _____
- □ Hernia Repair_____
- □ Neck/Back Surgery_____
- □ Bladder Surgery _____
- □ Prostate surgery/resection _____
- □ C-Section _____
- □ Orthopedic/joints _____
  _____
- □ Other _____

Please list all of your **CURRENT MEDICATIONS** (Continue listing on back of page if needed)
PLEASE INCLUDE ALL HERBS, VITAMINS, MINERALS AND OVER THE COUNTER MEDICATIONS

Medication Name	Dosage (Mg)	Prescribed by (Name/ Specialty)

ALLERGIES: (Medication/Food, indicate reactions): □ None known

SOCIAL HISTORY:

Marital Status: □ Married □ Single □ Divorced □ Widow(er) □ Domestic Partner
Work: □ Employed □ Unemployed □ Retired □ Disabled □ Laid Off
Current Occupation _____ Former Occupation _____
Education Level: _____School: _____
Children (Age): _____
Hobbies: _____
Alcohol: □ None □ Yes: How many drinks/week _____ What kind (beer, wine, etc.)_____
Tobacco: □ None □ Yes: What kind? _____ How much?_____ Started? _____ Quit?_____
How many glasses/cups/cans of caffeine (pop, coffee, tea) do you drink daily? _____
Do you exercise? □ Yes □ No If yes, how much? _____
Are you right or left handed? _____ Pets? _____

FAMILY HISTORY: Do any medical problems run in your immediate family? (PLEASE INDICATE WHO)

- □ None
- □ Diabetes _____
- □ Heart Disease_____
- □ Cancer/Type_____
- □ Thyroid_____
- □ Bleeding_____
- □ Stroke_____
- □ High Cholesterol_____
- □ High Blood Pressure_____
- □ COPD/Emphysema_____
- □ Arthritis_____
- □ Depression/Anxiety_____
- □ Autoimmune Disease/Type_____
- □ Other_____

REVIEW OF SYSTEMS: Do you have any of the following symptoms (please check yes or no for each)

GENERAL	Fever	□ No	□ Yes	Night Sweats	□ No	□ Yes
HEAD	Dizziness	□ No	□ Yes	Vision Loss	□ No	□ Yes
	Hearing Loss	□ No	□ Yes	Difficulty Swallowing	□ No	□ Yes
	Seizures	□ No	□ Yes	Fainting	□ No	□ Yes
BLOOD	Easy Bruising	□ No	□ Yes	Easy Bleeding	□ No	□ Yes
GLANDS	Weight Gain or Loss	□ No	□ Yes	Excessive Thirst	□ No	□ Yes
SKIN	Rash	□ No	□ Yes	Hair Loss	□ No	□ Yes
HEART	Chest Pain	□ No	□ Yes	Shortness of Breath	□ No	□ Yes
	Irregular Heart Beat	□ No	□ Yes	Ankle Swelling	□ No	□ Yes
LUNGS	Cough	□ No	□ Yes	Wheezing	□ No	□ Yes
STOMACH/INTESTINES	Constipation	□ No	□ Yes	Diarrhea	□ No	□ Yes
	Blood in Stools	□ No	□ Yes	Nausea/Vomiting	□ No	□ Yes
	Stomach Ulcers	□ No	□ Yes	Loss of Bowel Control	□ No	□ Yes
GENITALS/URINARY	Prostate Problems	□ No	□ Yes	Problems with Urinating	□ No	□ Yes
	Problems with Sex	□ No	□ Yes	Loss of Bladder Control	□ No	□ Yes
MENTAL	Anxiety	□ No	□Yes	Depression	□ No	□ Yes
NERVE/MUSCLE/JOINT	Joint Stiffness	□ No	□ Yes	Joint Swelling	□ No	□ Yes
	Muscle Pain	□ No	□ Yes	Muscle Weakness	□ No	□ Yes
	Chronic Widespread Pain	□ No	□ Yes	Difficulty Sleeping	□ No	□ Yes
	Chronic Fatigue	□ No	□ Yes	Tingling Sensations	□ No	□ Yes
	Worse with Cold Weather	□ No	□ Yes	Headaches	□ No	□ Yes
	Family Member with Fibromyalgia	□ No	□ Yes	Jaw Pain/TMJ	□ No	□ Yes

Patient/Guardian Signature: _____ Date _____

UPDATED: Signature: _____ Date _____

UPDATED: Signature: _____ Date _____

UPDATED: Signature: _____ Date _____