

Patient Medical History



Name: _____
Date of Birth: _____
Allergies to medications: _____
Allergies to iodine, contrast dye or shellfish? (circle all that apply)
Are you right-handed, left-handed or ambidextrous? _____
If patient is female, are you pregnant? _____

■ Diagnosed Medical Conditions

Do you have (circle all that apply):

High blood pressure Ulcers Thyroid disease Heart Disease Diabetes

Please list any others: _____

■ Operations (and other hospitalizations, list year)

■ Social History

Do you smoke or use tobacco in any form? (if so, how much and for how long) _____

Do you drink alcohol? (if so, how much and for how long) _____

Do you use street drugs? (if so, what type, how much and for how long) _____

Occupation: _____

Any possible exposure to the AID's virus? _____

- Do you have or have had any of the following
(please elaborate if necessary)



Stroke

Seizure

Headaches

Dizziness

Double vision or blurred vision

Hearing loss

Tinnitus (ringing in your ears)

Passing out spells

Memory loss

Speech problems

Swallowing problems

Urinary problems

Bowel problems

Sexual dysfunction

Arm or leg numbness

Arm or leg weakness

Chest pain

Slow or fast heart beat

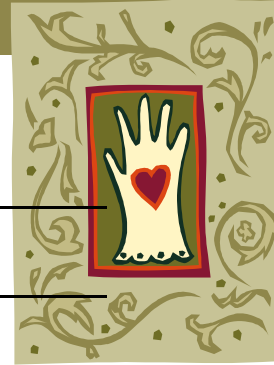
Rash

Fevers

Depression

Concussion

Why are we seeing you today?



How long have you had this problem? _____

Any history of similar problems? _____

Previous Tests for this problem? (CT, MRI, EMG, etc.) _____

Other doctors seen for the problem? _____

Previous medications tried for this problem? _____

Any relatives with similar medical problems (please describe) _____

Other comments: _____

