

**Family Medical Centers  
MEDICAL HISTORY**

NAME:	ALLERGIES:
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CURRENT MEDICATIONS:
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SURGERY (type and date): 1 2 3	ILLNESSES (requiring hospitalization) 1 2 3
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FAMILY HISTORY							
Do your parents or siblings have any of the following:							
	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Obesity				Hypertension			
Diabetes				Heart Disease			
Cancer				Kidney Disease			
Stroke				Arthritis			
TB				Migrane			
Asthma				Depression			
Epilepsy				Other			

PERSONAL HISTORY							
Have you ever: (Please check each item)				Do you: (Please check each item)			
YES	NO			YES	NO		
		Lived with anyone who had tuberculosis?				Wear glasses?	
		Coughed up blood?				Have vision in both eyes?	
		Bled excessively after an injury or tooth extraction?				Wear a hearing aid?	
		Attempted suicide?				Stutter or stammer habitually?	
		Been a sleepwalker?				Wear a brace or back support?	

Have you ever or do you now have							
YES	NO	DON'T KNOW	Please check to the left of each item	YES	NO	DON'T KNOW	Please check to the left of each item
			Scarlett fever, erysipelas				Tumor, growth, cyst or cancer
			Rheumatic fever				Rupture/hemia
			Swollen or painful joints				Piles or rectal disease
			Frequent or severe headache				Frequent or painful urination
			Dizziness or fainting spells				Bedwetting since age 12
			Eye trouble				Kidney stone or blood in urine
			Ear, nose or throat trouble				Sugar or albumin in urine
			Hearing loss				VD, Syphilis, Gonorrhea, Etc.
			Chronic or frequent colds				Recent gain or loss of weight
			Severe tooth or gum trouble				Arthritis, Rheumatism or Bursitis
			Sinusitis				Bone, joint or other deformity
			Hay fever				Lameness
			Head injury				Loss of finger or toe
			Skin diseases				Painful or "trick" shoulder or elbow
			Thyroid trouble or goiter				Recurrent back pain
			Tuberculosis				"Trick" or locked knees
			Asthma				Foot trouble
			Shortness of breath				Neuritis
			Pain or pressure in chest				Paralysis (include infantile)
			Chronic cough				Epilepsy or fits
			Palpitation or pounding heart				Car, train, sea or air sickness
			Heart trouble or murmur				Frequent trouble sleeping
			High or low blood pressure				Depression or excessive worry
			Cramps in your legs				Loss of memory or amnesia
			Frequent indigestion				Nervous trouble of any sort
			Stomach, liver or intestinal trouble				Periods of unconsciousness
			Gall bladder trouble or gallstones				<b>FEMALES ONLY: HAVE YOU EVER</b>
			Jaundice or hepatitis				Been treated for a female disorder
			Adverse reaction to serum, drug or medicine				Had a change in menstrual pattern
			Broken bones				
				DATE OF LMP			