

## MEDICAL AND FAMILY HISTORY

DATE \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

Examining Physician: (check one)  Mac A. Bowman, M.D.

Michael S. Holman, M.D.

**I. Present illness or reason for referral:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**II. Allergies:** \_\_\_\_\_

\_\_\_\_\_

**III. Medications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IV. Medical History: (Check all that apply)**

Heart Attack	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Renal Disease (Kidney)	<input type="checkbox"/>	CVA (Stroke)	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	Syncope (Passing Out)	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Vertigo (Dizziness)	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Post Menopausal	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>		<input type="checkbox"/>

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**V. Family History:** (see Medical History Chart on page 1)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sister: \_\_\_\_\_

Brother: \_\_\_\_\_

**VI. Surgical History:** \_\_\_\_\_

\_\_\_\_\_

**VII. Personal Data:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent weight gain/loss (circle one)

Occupation: \_\_\_\_\_

Smoking: \_\_\_\_\_ Packs per day \_\_\_\_\_ # of years \_\_\_\_\_

Alcohol intake: \_\_\_\_\_

Diet: \_\_\_\_\_

Caffeine intake (coke, chocolate, tea) \_\_\_\_\_

Psychological Problems: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ (check one)

Children: (ages/sex)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hobbies / Activities / Exercise:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_