MEDICAL HISTORY

Name: **Date:**

Allergies to Medications, X-Ray Dyes, or Other Substances? ○ No ○ Yes

If yes, please list the names of the medications and the type of reaction:

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History: *Circle all that apply*

1. Att. Deficit Disorder
2. Allergic Rhinitis
3. Anemia
4. Anxiety/Depression
5. Arthritis
6. Asthma
7. Atrial Fibrillation
8. Barretts Esophagus
9. Bipolar Disorder
10. Benign Prostatic Hyperplasia
11. Cancer _____
12. Cong. Heart Failure
13. Carpal Tunnel Synd.
14. Cholesterol Problem
15. Heart Murmur
16. Colitis
17. Colon Polyps
18. Chronic Kidney Dis.
19. Chronic Pain Synd.
20. Chronic Sinusitis
21. COPD
22. Crohn's Disease
23. CVA
24. Diverticulosis of Colon
25. Diabetes (Type1,Type2)
26. Eczema
27. Endometriosis
28. Esophageal Reflux
29. Erectile Dysfunction
30. Fibromyalgia
31. Fibroids
32. Gout
33. Genital Herpes
34. Heart Attack
35. Heart Disease
36. Hepatitis C
37. Hemorrhoids
38. Gastro. Reflux Disease
39. HIV/AIDS
40. Hiatal Hernia
41. History Drug Abuse
42. Hyperlipidemia
43. Hypertension
44. Thyroid Problem
45. Irritable Bowel Synd.
46. Insomnia
47. Kidney Disease
48. Kidney Stones
49. Lung Nodule
50. LFTs Abnormal
51. Migraine
52. Mitral Valve Prolapse
53. Obesity
54. Ovarian Disease
55. Sleep Apnea
56. Osteoporosis
57. Osteoarthritis
58. Peptic Ulcer Dis.
59. Periph. Vascular Dis.
60. Restless Legs
61. Tuberculosis
62. Ulcerative Colitis

Other: _____

Epworth Sleepiness Scale: Age: _____ Male/Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just being tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and Reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. movie theater or meeting)	_____
Lying down to rest in afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
As a passenger in a car for 2 hours without a break	_____

Sleep History:

Usual Bed Time	_____	Sleepy/tired during the day	Y/N	Snoring	Y/N
Sleep Onset Time	_____	Sleepy/tired while driving	Y/N	Restless Legs	Y/N
Nightime Awakenings	_____	Sleepy/tired while at work	Y/N	Sleep Paralysis	Y/N
		Daytime Sleepiness	Y/N	Waking up and gasping for air	Y/N

Gynecologic and Obstetric History:

Age of Periods: _____ Frequency: _____ Length of Periods: _____ Pregnancies: _____ Births: _____

Please List and Supply Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____

Immunization History:

Hepatitis B	Y/N	When: _____
Pneumovax Immunization	Y/N	When: _____
Flu Immunization	Y/N	When: _____
Tetanus Immunization	Y/N	When: _____
Other: _____		When: _____

When was your last…

Pap Smear:	_____
Mammogram:	_____
Breast Exam:	_____
Cholesterol Check	_____
Stool Check for Blood	_____
Prostate Exam	_____

Medications:

(Including prescriptions, over-the-counter, vitamins, herbs, etc)

Drug Name	Dosage	Drug Name	Dosage

Prevention History:

Do you wear your seat belt?	Y/N	
Do you smoke?	Y/N	If yes, how many packs per day? _____
Do you drink alcohol?	Y/N	If yes, how much per week? _____
Do you drink coffee?	Y/N	If yes, how many cups per day? _____
Do you drink tea?	Y/N	If yes, how many cups per day? _____
Do you use drugs? (Marijuana, Cocaine, Crack Cocaine, etc)	Y/N	If yes, explain: _____
Have you ever engaged in any activity that has put you at risk of getting AIDS?	Y/N	If yes, explain: _____
Have you ever worked with any hazardous material/asbestos?	Y/N	If yes, explain: _____
Do you have a living will?	Y/N	

Family History:

Please list illness and age of diagnosis

	Illness	Age of Diagnosis
Father		
Mother		
Sister		
Brother		
Children		