



2439 Sonoma St., Suite 101 • REDDING, CALIFORNIA 96001  
 PHONE 530-241-1300 FAX 530-241-0200

Date: \_\_\_\_\_

## PATIENT'S MEDICAL HISTORY

ACCT. # \_\_\_\_\_

1. Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_
2. Describe briefly your reason for coming to my office: (date of injury, if applicable): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### GENERAL HEALTH

1. Are you allergic to any foods?  Yes  No  
 If so, list foods & type of reaction: \_\_\_\_\_
2. Are you allergic to any medication?  Yes  No  
 If so, list medications & type of reaction: \_\_\_\_\_
3. Do you have any other allergies such as creams, tape, latex, etc.?  Yes  No  
 If so, please list: \_\_\_\_\_

### CURRENT MEDICATIONS

(Include herbs, vitamins & any other over-the-counter medications. Provide a separate sheet if necessary.)

| MEDICATION | STRENGTH | DOSAGE | PURPOSE |
|------------|----------|--------|---------|
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |
|            |          |        |         |

Do you bruise or BLEED EASILY?  Yes  No      Do you take aspirin regularly?  Yes  No

### PAST MEDICAL HISTORY

4. Are you being treated for any health problems now or have you been treated within the past five years?  Yes  No  
 If so, what type of illness: \_\_\_\_\_  
 \_\_\_\_\_

5. Have you ever been treated for one of the following:

|                              | Yes | No | Year |                            | Yes | No | Year |
|------------------------------|-----|----|------|----------------------------|-----|----|------|
| Diabetes                     |     |    |      | Thyroid Problem            |     |    |      |
| Tuberculosis                 |     |    |      | HIV/AIDS                   |     |    |      |
| Kidney Disease               |     |    |      | Liver Disease or Hepatitis |     |    |      |
| High Blood Pressure          |     |    |      | Blood or Bleeding Problems |     |    |      |
| Heart or Circulatory Disease |     |    |      | Cancer                     |     |    |      |
| Heart Attack                 |     |    |      | Arthritis                  |     |    |      |
| Lung problem or pneumonia    |     |    |      | Epilepsy or seizures       |     |    |      |

6. Do you ever:

Yes No

Yes No

|   |  |  |                                      |  |  |
|---|--|--|--------------------------------------|--|--|
| Cough up blood                            |  |  | Have stomach problems                |  |  |
| Vomit up blood/blood in stools            |  |  | Feel faint or dizzy                  |  |  |
| Have shortness of breath                  |  |  | Have nose problems (runny or stuffy) |  |  |
| Have chest pain                           |  |  | Have dry eyes                        |  |  |
| Have heart palpitations                   |  |  | Have problems with your vision       |  |  |
| Have Skin Disorders/Problems with healing |  |  | Skin disease                         |  |  |

Please explain all yes answers: \_\_\_\_\_

7. Please list any operations you have had, including dates: \_\_\_\_\_

8. Have you had any major injuries?  Yes  No When: \_\_\_\_\_ How injured: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_

9. When was your last mammogram? \_\_\_\_\_ Where did you get your mammogram? \_\_\_\_\_

(facility name)

10. When was your last EKG? \_\_\_\_\_ Where did you get your EKG? \_\_\_\_\_

(facility name)

11. Have you ever been under care for **psychological or emotional problems**?  Yes  No If yes, please describe: \_\_\_\_\_

12. Present weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Best weight for you: \_\_\_\_\_ Height: \_\_\_\_\_

## SOCIAL HISTORY

1. Marital Status: \_\_\_\_\_

2. How many children do you have? \_\_\_\_\_

3. Tobacco use?  Yes  No Smoke  Chew  How much per day? \_\_\_\_\_

When did you start? \_\_\_\_\_ If you smoked in the past, when did you quit? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

4. What type of work do you do? \_\_\_\_\_

5. Do you drink alcohol? \_\_\_\_\_ How much and how often? \_\_\_\_\_ When was your last drink? \_\_\_\_\_

6. Any history of IV drug use?  Yes  No \_\_\_\_\_

## FAMILY HISTORY

Are there any illnesses or cancer that runs in your family?

Please provide details: \_\_\_\_\_