

Medical History

Date:	Name:	Age	
Height:	Weight:	D.O.B.	
Name of the Doctor who asked you to see Dr. Wagner:		Primary Doctor?	
Reason for seeing Dr. Wagner?			
Please list all of your other medical problems (such as diabetes, high blood pressure, old stroke etc) (typed list is OK):			
Please list all surgeries and procedures you've had (no matter how long ago) and approximate year (typed list is OK):			
Are you allergic to any medications or foods? Please list:			
Are you allergic to Latex?			
Do you take aspirin daily or several times a week?			
Do you take coumadin/warfarin?			
Do you take prednisone or steroids?			
Do you take herbs, roots, vitamins or medicinal tea?			
Please write a list of any medications (prescription or over the counter) that you take on a regular basis:(typed list is OK):			
Name of Medication	Dose	How many times per day?	
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> as needed	
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> as needed	
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> as needed	
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		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> as needed	
Social History:			
Marital Status (circle please) single married divorced widow			
Occupation			
Drink Alcohol? How many drinks per day?			
Smoke? How many pack/cigarettes per day?			
Recreational drugs? (This is very important for anesthesia for surgery!) Which?			
Family History:	Mother	Father	Other
Cancers (what type)			
Diabetes:			
Heart Disease:			
Stroke:			
Other:			
Ovarian, Colon, Uterine cancer?			

Medical History
(Current and old problems)

	Y	Symptom or Condition	Describe	
Neuro	<input type="checkbox"/>	Convulsions/Seizures		
	<input type="checkbox"/>	Migraines/Headaches		
	<input type="checkbox"/>	Strokes/TIAs		
	<input type="checkbox"/>	Paralysis/Weakness		
Heart:	<input type="checkbox"/>	Chest pain/Angina	Cardiologist's Name:	
	<input type="checkbox"/>	Shortness of breath		
	<input type="checkbox"/>	High Blood Pressure		
	<input type="checkbox"/>	Heart failure/congestive heart failure		
Lungs	<input type="checkbox"/>	Heart Attack/MI		
	<input type="checkbox"/>	Chronic cough	Pulmonologist's Name:	
	<input type="checkbox"/>	Sleep apnea or snoring		
	<input type="checkbox"/>	Asthma or Emphysema		
Kidneys	<input type="checkbox"/>	Recent colds or pneumonia		
	<input type="checkbox"/>	Blood in Urine		
	<input type="checkbox"/>	Frequent bladder infections		
	<input type="checkbox"/>	Kidney infections or failure		
Stomach area	<input type="checkbox"/>	Blood in Stool or Black stools		
	<input type="checkbox"/>	Vomiting blood		
	<input type="checkbox"/>	Chronic diarrhea or constipation		
	<input type="checkbox"/>	Nausea or vomiting		
	<input type="checkbox"/>	Pain or difficulty swallowing		
	<input type="checkbox"/>	Chronic heartburn/ Acid reflux		
	<input type="checkbox"/>	Hepatitis	Type? A B C D E Don't Know	
	<input type="checkbox"/>	Stomach ulcers		
	<input type="checkbox"/>	Pancreatitis		
	<input type="checkbox"/>	Gallstones		
	Endocrine (Hormones)	<input type="checkbox"/>	Diabetes	Found as a child or adult?
		<input type="checkbox"/>	Thyroid trouble	Any surgery? Radioactive pill ablation?
<input type="checkbox"/>		Early Menopause?		
Blood System	<input type="checkbox"/>	Anemia		
	<input type="checkbox"/>	Easy Bruising		
	<input type="checkbox"/>	Blood clots in deep veins or to lungs		
	<input type="checkbox"/>	Blood transfusions		
	<input type="checkbox"/>	HIV/AIDS		
	<input type="checkbox"/>	Blindness/ Cataracts/ Glaucoma/ Macular Degeneration		
Vision/Eyes	<input type="checkbox"/>	Eyeglasses or contacts		
Hearing/Ears	<input type="checkbox"/>	Deafness/Hearing aids		
Mouth	<input type="checkbox"/>	Vertigo or Chronic ringing in the ears		
	<input type="checkbox"/>	Removable dentures or dental appliances		
Skin	<input type="checkbox"/>	Chronic gum infections or teeth problems		
	<input type="checkbox"/>	Chronic rashes or conditions		
Musculoskeletal	<input type="checkbox"/>	Unusual moles		
	<input type="checkbox"/>	Fibromyalgia		
	<input type="checkbox"/>	Arthritis	Rheumatoid? Osteoarthritis?	
	<input type="checkbox"/>	Any joint replacements?		
	<input type="checkbox"/>	Carpal tunnel syndrome		
Psychiatric	<input type="checkbox"/>	Depression or Anxiety disorder?	Psychiatrist's Name:	
	<input type="checkbox"/>	Schizophrenia/Hallucinations	Have you ever been hospitalized?	
	<input type="checkbox"/>	Anorexia/Bulimia/ or Suicidal attempts		
Constitutional	<input type="checkbox"/>	Fever/Chills/Night sweats		
	<input type="checkbox"/>	Weight loss or gain	Dieting? Wt loss surgery?	
Female History	<input type="checkbox"/>	Number of pregnancies?		
	<input type="checkbox"/>	Age at first live birth?		
	<input type="checkbox"/>	Ages and sex of your children		
	<input type="checkbox"/>	Any miscarriages or abortions	Miscarriages: Abortions:	
	<input type="checkbox"/>	Age at first menses/period		
	<input type="checkbox"/>	Date of last menses/period		
	<input type="checkbox"/>	Did you nurse/breast feed?	For how long?	
	<input type="checkbox"/>	If you've had a hysterectomy do you have ovaries still?	One Both None?	
	<input type="checkbox"/>	Have you ever taken Hormones or birth control?		