ALPHA MEDICAL CENTRE

Medical History

Patient Name: _____ **Date:** _____

Personal Information

Name_____ Age_____ Birth Date_____/_____/_____

Occupation_____
Spouse's Name_____
Children's Name/Ages_____
_____
Referred By_____

Allergies (Medication, Food, Latex, Dye and Miscellaneous)

Name of Agent	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

High Blood Pressure	Diabetes	Appendix
Obesity	Heart Disease	Hernia
Pneumonia	Asthma/Bronchitis	Gall Bladder
Peptic Ulcer	Hay Fever	Hemorrhoids
Low Back Problems	Anemia	Tonsil
Stroke	Skin Diseases	_____
Anxiety	Depression	_____
_____	_____	_____
_____	_____	_____

Family History

Illness Cancer (Kind/Organ)	Family Member	Age Diagnosed
_____	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Psychiatric Illness	_____	_____
Substance Abuse	_____	_____
Bleeding Disorder	_____	_____
Glaucoma	_____	_____

Patient Name: _____ **Date:** _____

Immunization History and Preventive Medicine

Hepatitis B Yes/No When? _____ Pneumovax Yes/No When? _____
Flu Vaccine Yes/No When? _____ Tetanus Shot Yes/No When? _____

Pap Smear _____ Breast Exam. _____ Mammogram _____
Cholesterol _____ Stool for Blood _____ Prostate Exam. _____
Colonoscopy/ Sigmoidoscopy _____

Do you wear seat belt?	Yes/No	
Do you wear bike helmet?	Yes/No	NA
Do you exercise regularly?	Yes/No	
Do you smoke?	Yes/No	
Do you drink alcoholic beverages?	Yes/No	
Do you drink coffee/tea?	Yes/No	
Do you use Recreational Drugs?	Yes/No	
Is Gun in your home kid safe?	Yes/No	NA
Are you at increased risk for HIV?	Yes/No	
Do you want to be tested for HIV?	Yes/No	
Did you ever get exposed to chemicals?	Yes/No	
Exposure to physical abuse?	Yes/No	
Do you have a "Living Will"?	Yes/No	

Medicine	Dose	Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems

General	Skin	Head/Eyes/Ears/Nose/Throat/Neck				
__ Weakness	__Color Changes	__Headache	__Head Injury	__Glasses	__Contacts	__Hoarseness
__Fatigue	__Itching	__Blurred Vision	__Glaucoma	__Redness	__Dryness	__Stiff Neck
__Night Sweats	__Nail Changes	__Deafness	__Ringing	__Discharge	__Earache	__Lumps
__Fever	__Rash	__Dizziness	__Loss of balance	__Bleeding Nose	__Runny Nose	__Trouble
__Chills	__Moles	__Sinus Cong.	__Dental problem	__Gum Disaease	__Sore Throat	Swallowing

Breasts	Lungs	Heart	Gastrointestinal		Blood
__Discharge	__Cough	__Murmur	__Abdominal Pain	__Diarrhea	__Anemia
__Lumps	__Phlegm	__Palpitations	__Nausea	__Bloating	__Easy Bruising
__Skin/Nipple Change	__Short of Breath	__Swelling Feet	__Vomiting	__Hemorrhoids	__Bleeding
__Bleeding	__Wheezing	__Cold Extremity	__Belching	__Poor Appetite	__Painful Nodes
__Pain	__Congestion	__Chest Pain	__Indigestion	__Heartburn	__Swollen Nodes
	__Pain	__Passing out	__Bloody Stools	__Black Stools	__Red Spots

Genitourinary	Musculoskeletal	Neurological	Psychiatric	Endocrine
__Urgency	__Muscle pain	__Seizures	__Depression	__Wt. Loss
__Incontinence	__Cramps	__Tremors	__Insomnia	__Wt. Gain
__Impotence	__Twitching	__Loss of sensation	__Anxiety	__Hoarseness
__Discharge	__Joint Stiffness	__Paralysis	__Alcoholism	__Heat/Cold Intolerance
__Cloudy Urine	__Back Pain	__Numbness	__Drug Abuse	__Hair Changes
__Frequent Urination	__Joint Swelling	__Loss of Memory	__Suicidal	