

MEDICAL DATA SHEET

Name _____ Date: _____

Medical History. List current or previous medical conditions. **Examples** include high blood pressure, heart attack, stroke, diabetes, cancer, thyroid problems, depression, arthritis, blood clots.

Condition

Doctor

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Surgical History. Please list all surgeries.

Type of surgery

Doctor (if known)

Year

- | Type of surgery | Doctor (if known) | Year |
|-----------------|-------------------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |

Current Medications. Please provide dose and frequency

Medication

Dose

Frequency

Medication

Dose

Frequency

- | | |
|----------|-----------|
| 1. _____ | 8. _____ |
| 2. _____ | 9. _____ |
| 3. _____ | 10. _____ |
| 4. _____ | 11. _____ |
| 5. _____ | 12. _____ |
| 6. _____ | 13. _____ |
| 7. _____ | 14. _____ |

(Over Please)

Allergies to Medications or Metals/Reactions to Medications Name _____

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Social History

Smoking: Never _____ Previous (list year quit) _____ Current (list packs/day) _____

Alcohol: None _____ Rare _____ Occasional _____ Frequent _____

Family History. Please circle all that apply and give details (i.e. mother, brother, grandfather, etc.)

Cancer Heart Disease Arthritis Reaction to Anesthesia Abnormal Bleeding

Is there a chance you could be pregnant? _____

Have you ever been told you have Hepatitis C? _____

Review of Systems. Please circle all conditions or symptoms that you currently experience. Do not circle a condition if it is already listed under "Medical History".

Other

- | | |
|--------------------------|---|
| 1. General | Fevers, recent weight changes, abnormal sweats, fatigue _____ |
| 2. Skin | Cancer, rash _____ |
| 3. Eyes, nose, throat | Glaucoma, cataracts, dentures, hearing loss _____ |
| 4. Lungs | Cough, asthma, shortness of breath, emphysema _____ |
| 5. Heart and circulation | Chest pain, heart attack, heart murmur, blood clots, hypertension _____ |
| 6. Endocrine system | Thyroid problems, diabetes, menopause _____ |
| 7. Gastrointestinal | Heartburn, ulcer, GI bleeding, hepatitis, hernia _____ |
| 8. Urinary tract | Incontinence, prostate problem, bladder infection, kidney stone _____ |
| 9. Nervous system | Stroke, seizures, migraines, nerve damage _____ |
| 10. Musculoskeletal | Fractures, arthritis, gout, osteoporosis _____ |
| 11. Mental, emotional | Anxiety, depression, bipolar _____ |

Patient or Designee Date

Physician or PA Date