PRO-HEALTH SERVICES MEDICAL HISTORY

Name:_____DOB: _____

What Chronic Medical Problems Do You Have?

_____

_____

_____

_____

_____

_____

What Surgeries Have You Had?

_____

_____

_____

_____

_____

_____

Place An "X" In The Box If Your Family Member Has The Condition.

	Diabetes	High Blood Pressure	Heart Disease	Colon Cancer	Breast Cancer	Prostate Cancer
Mother						
Father						
Mom's Mom						
Mom's Dad						
Dad's Mom						
Dad's Dad						
Siblings						

What Other Diseases Run In Your Family?

_____

_____

_____

Are You Never-Married, Married, Divorced or Widowed? _____

Who Do You Live With? _____

What Type of Work Do You Do?_____

What Drug Allergies Do You Have?

_____

_____

_____

What Medications Do You Currently Take?

_____

_____

_____

_____

_____

_____

_____

Have You Had Any Exposure To Asbestos or Other Harmful Chemicals? _____

Do You Smoke? Yes No Quit

If yes, how much? _____

Do You Drink Alcohol? Yes No Quit

If yes, how much? _____

Do You Use Any Illicit Drugs? Yes No Quit

If yes, what? _____

For Women Only

How many times have you been pregnant? _____

How many children have you given birth to? _____

Name:_____ **DOB:_____**

Review Of Systems

In the past 6 months, have you had problems with the following:

General

Fever	Yes Or No
Chills	Yes Or No
Weight loss	Yes Or No
Weight gain	Yes Or No
Fatigue	Yes Or No
Weakness	Yes Or No
Insomnia	Yes Or No

CV

Chest pain	Yes Or No
Palpitations	Yes Or No
Swelling of legs	Yes Or No
Heart Murmur	Yes Or No
Dizziness	Yes Or No

GI

Constipation	Yes Or No
Diarrhea	Yes Or No
Vomiting	Yes Or No
Abdominal pain	Yes Or No
Nausea	Yes Or No
Hermorrhoids	Yes Or No
Bloody stool	Yes Or No

Respiratory

Short of breath	Yes Or No
Cough	Yes Or No

Eyes

Blurry vision	Yes Or No
Double Vision	Yes Or No

ENT

Nasal obstruction	Yes Or No
Nosebleeds	Yes Or No
Ear pain	Yes Or No
Sore throats	Yes Or No

MS

Muscle pain	Yes Or No
Joint pain	Yes Or No
Joint swelling	Yes Or No

Psychological

Anxiety	Yes Or No
Depression	Yes Or No
Irritability	Yes Or No

Skin

Persistent Sores	Yes Or No
Rashes	Yes Or No

Neurological

Headaches	Yes Or No
Tingling	Yes Or No
Numbness	Yes Or No

Endo

Increased thirst	Yes Or No
Hot flashes	Yes Or No
Night sweats	Yes Or No
Thyroid problems	Yes Or No

Heme

Easy Bruisability	Yes Or No
Bleeding Easy	Yes Or No

Lymph

Swollen glands	Yes Or No

GU

Discharge	Yes Or No
Itching	Yes Or No
Dysfunction	Yes Or No

I affirm that the above is true.

_____ _____

Signature Date