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SHORT MEDICAL HISTORY

NAME_____
DATE_____ AGE_____

Primary Doctor: _____ **Primary Dr's Phone#:** (____) _____- _____

1. **PRESENT ILLNESS** (Reason for seeing Dr. Freehling?)_____

2. OTHER MEDICAL HISTORY:

A. What other problems are you being treated for by any other doctor? _____

_____

B. List all current medications:	Strength/Dosage:	Reason for the Medication(s):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. List ALLERGIES to medications: _____

D. List all surgeries you have had (list year or age): Tonsillectomy_____ Adenoidectomy _____

Other(s) _____

3. Do you have any **BLOOD RELATIVES** with:

	(YES) Relation		(YES) Relation
High blood pressure	( ) _____	diabetes	( ) _____
Heart disease	( ) _____	thyroid problem	( ) _____
Stroke	( ) _____	kidney disease	( ) _____
Lung problems	( ) _____	obesity	( ) _____
Cancer of? _____	( ) _____	other?	( ) _____

4. SOCIAL HISTORY

A. Do you smoke or chew tobacco? Yes _____ How much daily? _____ How long? _____
No _____
Did you in the past? If so, how much? _____ How long? _____
When did you quit? _____

B. Were/are your parents smokers? Mother: Yes _____ No _____ Father: Yes _____ No _____

C. Do you use alcohol? Yes _____ How much daily? _____ or weekly _____ How long? _____
No _____
Did you in the past? If so, how much? _____How long? _____
When did you quit? _____

D. Have you had problems with alcohol or drug abuse? Yes _____ No _____

E. What is your occupation? _____

5. GENERAL HEALTH

Present Height _____ Weight _____

If you are an adult, has your weight been stable? Yes _____ No _____