Patient Medical History - Initial Visit

David R. Brown, M.D., Ph.D., P.A.

Name: _____ **Date of Birth:** _____

Personal History (past and present)

Major Illness	Date of Onset

Surgery	Date of Surgery

Serious Injury	Date

Drug Reactions & Allergies

_____
_____
_____
_____

Blood Transfusions

Yes ☐ No ☐

If yes, give dates:

_____
_____

Current Medications

Drug Name	Dose	When Taken

Miscellaneous

Marital Status: _____ Tobacco: _____

Religion: _____ Alcohol: _____

Citizenship: _____ Other: _____

Occupation: _____ Exercise: _____

Review of Systems and Family History (me and my relatives)

(check all that apply)

Medical Condition	Self	Relative	Which Relatives?
Fever/Chills/Sweats	☐	☐	
Weight (gain/loss)	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
High Triglycerides	☐	☐	
Gout	☐	☐	
Hormone Problem	☐	☐	
Diabetes Mellitus	☐	☐	
Thyroid Problem	☐	☐	
Cancer	☐	☐	
Headaches	☐	☐	
Eye Problems	☐	☐	
Sinus and Ear	☐	☐	
Mouth and Throat	☐	☐	
Heart Disease	☐	☐	
Lung Disease	☐	☐	
Stomach and Intestine	☐	☐	
Liver and Gall Bladder	☐	☐	
Pancreas and Spleen	☐	☐	
Kidney and Bladder	☐	☐	
Muscular Disease	☐	☐	
Spine and Bone	☐	☐	
Joint Disease	☐	☐	
Brain (stroke)/Nerves	☐	☐	
Psychiatric Problems	☐	☐	
Lymph Glands	☐	☐	
Genital/Reproductive	☐	☐	
Blood Problems	☐	☐	
Autoimmune/Collagen	☐	☐	
Circulation Problems	☐	☐	
Other	☐	☐	

Women Only

Menstrual Cycles

age at first cycle: _____

date of last cycle: _____

comments: _____

_____

_____

_____

Pregnancies

(include miscarriages and abortions)

Date	Outcome