Maurice Jove M.D. Jeff Traub M.D. Scott Barbour M.D. Brian Vanderhoof D.O.

COMPLETE MEDICAL HISTORY FORM

NAME _____ DATE_____

Date of Birth _____ AGE _____

Please describe your main problem _____

How long has this been present? _____

Is this the first time you had such a problem?_____

Other problems you wish to discuss? _____

What do you consider your health to be? EXCELLENT GOOD FAIR POOR

Are you _____ Right-handed? _____ Left-handed?

Do you consider yourself disabled? Y N

DATE	SURGERY	REASON	DOCTOR

Have you even been hospitalized for non-surgical reasons? If so, please explain _____

Have you ever had any of the following? Please check those that apply

	Arthritis/bursitis		Glaucoma		Strokes
	Rheumatoid Arthritis		Hayfever		TIA
	Excessive bleeding		Thyroid Disease		Gall bladder problems
	Diabetes		Asthama		Hemorrhoids
	Cancers List below		Lung disease		Hepatitis or jaundice
	Epilepsy or seizures		Pneumonia		Hernia
	Gout		Pulmonary Embolism		Kidney disease
	Leukemia		Tuberculosis		Kidney stones
	Lupus		Blood Clots		pancreatitis
	Psoriasis		Heart Attack		Ulcers
	Scarlet Fever		Heart Disease		Venerial Disease
	Depression		Hypertension		Deformities
	Tumors or growths		Rheumatic Fever		Loss of a limb
	Chicken pox		Measles		Mumps
	Rubella				

Other illnesses and date _____

Accidents and date _____

Do you exercise on a regular basis? Y N How much / often? _____

Do you use tobacco or smoke? Y N How much / often? _____

Do you consume Alcohol? Y N How much / often? _____

Do you have a history of drug abuse Y N

List medication and dosages

Medication	Strength	Frequency

Have you even been on prednisone? Y N Coumadin Y N

Please list any drug allergies you have and your reaction

Medication	Reaction

Do you have a special diet or food allergies _____

Please give your family history

	Living / Age	Deceased	Age and Cause of Death
Father			
Mother			
Siblings			

Is there a family history of?

	Heart Disease		Cancer
	Hypertension		Bone or muscle disease
	Diabetes		Died from anesthesia
	Kidney disease		

In the past SIX Months, have you had any of the following?

	Weight gain / loss		Shortness of breath
	Frequent headaches		Chest pain
	Head injury		Abnormal EKG
	Loss of memory		Chronic cough
	Ear, nose, or throat problems		Coughing up blood
	Ringing in ears		Indigestion
	Eye problems		Jaundice
	Nose bleeds		Numbness
	Frequent colds		Painful urination
	Frequent sore throats		Foot trouble
	Difficulty / pain with swallowing		Sugar or albumin in urine
	Severe gum or tooth trouble		Frequent urination
	Recurrent back pain		Bowel or bladder difficulty
	Frequent diarrhea		Bloody bowel movements
	Black stools		Recurrent nausea or vomiting
	Fatty food intolerance		Black outs
	Depression or worry		Painful / red swollen joints
	Weakness / pain in muscles or joints		

Signature