

Medical History

Patient Name _____ Date of Birth _____

Nickname (name you prefer to be called): _____

Why did you come to see Dr. Carlton?

What would you like to get out of your visit with Dr. Carlton?

What medical concerns do you have?

Have there been any recent changes in your life or your family such as a marriage, divorce, birth, death, move or loss of a job?

Medical History Continued

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Answer the following yes/no questions by putting an x in the appropriate box

	Yes	No
Do you think that there is something wrong with your health?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get stomachaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever fainted?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel too hot or too cold?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel constipated?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have food come up into your mouth unintentionally?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Does it burn or hurt when you urinate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any rashes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have muscle or joint pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have discharge from your vagina (if you're a girl) or penis (if you're a boy)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned that you might have a sexually transmitted disease (STD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke pot?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about your height?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up during the night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you worry a lot?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever hurt yourself (cut, burned, scratched, etc.) on purpose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever thought about hurting yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other problems or concerns that you would like to discuss with Dr. Carlton?	<input type="checkbox"/>	<input type="checkbox"/>

Medical History Continued

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Do you have any chronic medical problems?

Have you ever been admitted to the hospital? If so, please list the name of the hospital, the dates of the admission and the reason for the admission.

Have you ever surgery? If so, please list the type of surgery and the date.

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Have you had any of the following illnesses or problems?

	yes	no	When/Describe
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major Accidents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sports Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric illnesses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug or Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Do you take any medications? If so, please list them below, including what the medication is treating, the dosage and how frequently it's taken. Please include vitamins and nutritional supplements.

Do you have any allergies to any medications? If so, please list the medication and the reaction.

Do you have any allergies to any foods? If so, please list the food and the reaction.

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Only complete this page if you are female

How old were you when you first got your period? _____

How often do you get your periods? _____

How long do your periods last? _____

Do you get cramps with your period? _____

When was your last period? _____

Have you ever lost your period for 3 or more months? _____

Have you ever had or been treated for a sexually transmitted disease? _____

Have you ever had a Pap smear? _____

Have you ever had an abnormal Pap smear? If so, how was it treated? _____

Have you ever been pregnant? _____

Do you think that you might be pregnant? _____

Are you using birth control? If so, what are you using? _____