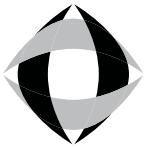
Medical History



Drs. Campbell Cunningham
Taylor & Haun

Your Information

Patient Name _____ Chart# _____ Today's Date: _____

Review of Systems—Do you have a problem with any of the following? Please circle YES or NO.

1. Constitutional—Weight Loss/Gain, Fever: ..... Yes ☐ No ☐
2. Ear, Nose, Throat, Mouth—Sinus ..... Yes ☐ No ☐
3. Respiratory—Lung, breathing, asthma, TB: ..... Yes ☐ No ☐
2. Gastrointestinal—Stomach, Intestines, Hepatitis—Sinus ..... Yes ☐ No ☐ Diagnosis date:
   a. Diabetes ..... Yes ☐ No ☐ _____
      Treatment: diet control ☐ oral agents ☐ insulin ☐ other ☐ _____
      Medical complication: kidney ☐ vascular ☐ eye ☐ other ☐ _____
   b. Heart attack ..... Yes ☐ No ☐ _____
      Angina or chest pain ..... Yes ☐ No ☐ _____
      Heart failure ..... Yes ☐ No ☐ _____
      Irregular or rapid heart beat ..... Yes ☐ No ☐ _____
      Cardiac pacemaker inserted ..... Yes ☐ No ☐ _____
   c. High blood pressure ..... Yes ☐ No ☐ _____
   d. Stroke or TIA ..... Yes ☐ No ☐ _____
   e. Anemia ..... Yes ☐ No ☐ _____
   f. Asthma ..... Yes ☐ No ☐ _____
      Emphysema and/or bronchitis ..... Yes ☐ No ☐ _____
      Pneumonia ..... Yes ☐ No ☐ _____
      Tuberculosis ..... Yes ☐ No ☐ _____
   g. Liver disease or jaundice ..... Yes ☐ No ☐ _____
   h. Stomach or duodenal ulcer ..... Yes ☐ No ☐ _____
   i. Kidney stones / other kidney disease ..... Yes ☐ No ☐ _____
   j. Arthritis: rheumatoid ☐ osteo ☐ ..... Yes ☐ No ☐ _____
   k. Cancer or tumor ..... Yes ☐ No ☐ _____
      Type: _____
   Treatment: _____
   l. Thyroid disease: underactive ☐ overactive ☐ ..... Yes ☐ No ☐ _____
      Treatment: _____
   m. Migraine ..... Yes ☐ No ☐ _____
n. Blood clot in legs ..... Yes ☐ No ☐ _____
o. Bleeding disorders ..... Yes ☐ No ☐ _____
   p. Transfusions of blood or plasma ..... Yes ☐ No ☐ _____
q. HIV positive, AIDS ..... Yes ☐ No ☐ _____
   r. Other medical problems ..... Yes ☐ No ☐ _____
      Please describe: _____
4. Are you allergic to any medications or foods? ..... Yes ☐ No ☐ _____
   If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below: _____

Eye medication(s):				**All other medication(s):**		
Name	Dose	Frequency	Eye	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____