Comprehensive Medical Care of Danbury

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MEDICAL HISTORY

Name:
Today's Date:
Date of Birth:
Sex: Male/ Female

Drug Allergies	Medical/ Mental Problems		Medications	
1.	1.	4.	1.	4.
2.	2.	5.	2.	5.
3.	3.	6.	3.	6.

Medical History

☐ Abdominal Pain – Chronic	☐ Gall Bladder Trouble	☐ Pneumonia	☐ Chicken Pox ☐ Polio ☐ Mumps
☐ Allergies/Hayfever	☐ Gout	☐ Prostate Disease	☐ Measles ☐ Rubella
☐ Anemia	☐ Hair Loss	☐ Psoriasis ☐ Eczema	☐ Rheumatic Fever
☐ Ankles – Swollen	☐ Headaches – Frequent	☐ Rashes ☐ Hives	☐ Scarlet Fever ☐ Tuberculosis
☐ Appetite – Loss of	☐ Heart Murmur	☐ Sexual/Menstrual Dysfunction	☐ Herpes
☐ Arthritis/Rheumatism	☐ Hemorrhoids	☐ Sinus Trouble	☐ Other:
☐ Asthma/Wheezing	☐ Hernia	☐ Stools – Bloody or Tarry	**FEMALES** – *Please Complete*
☐ Back Pain – Recurrent	☐ High Blood Pressure	☐ Stroke	Pregnant? ☐ Yes ☐ No
☐ Bone Fracture/Joint Injury	☐ Indigestion or Heartburn	☐ Swallowing Difficulty	Planning Pregnancy? ☐ Yes ☐ No
☐ Bowel Habits – Change in	☐ Infections – Frequent	☐ Tetanus	Menstrual Flow:
☐ Bronchitis/Chronic Cough	☐ Jaundice/Hepatitis	☐ Throat – Sore – Frequent	☐ Regular ☐ Irregular ☐ Pain / Cramps
☐ Cancer	☐ Kidney Stones	☐ Thyroid Disease	Days of flow Length of Cycle
☐ Chest Pain	☐ Lactose Intolerance	☐ Tremor / Hands Shaking	Date – 1st day of last period:
☐ Convulsions/Seizures	☐ Leg Pain - Walking	☐ Ulcers - Peptic	☐ Pain/Bleeding during or after sex.
☐ Diabetes	☐ Memory Loss	☐ Urethral Discharge	Number of:
☐ Diarrhea ☐ Constipation	☐ Mental Illness	☐ Urination-☐Overnight>Than Twice	Pregnancies Abortions
☐ Diphtheria	☐ Moodiness - Excessive	☐ Decrease in Force/Flow	Miscarriages Live Births
☐ Diverticulosis ☐ Crohn's/Colitis	☐ Muscle Weakness	☐ Painful ☐ Loss of Control	Birth Control Method
☐ Dizziness/Fainting	☐ Nausea/Vomiting – Persistent	☐ Urine – Blood in	B.C. Pill (Name):
☐ Ear Infections – Frequent	☐ Nervousness ☐ Depression	☐ Varicose Veins/Phlebitis	☐ Flushing/Menopause
☐ Ear – Ringing In	☐ Nose Bleeds	☐ Venereal Disease	Date of Last PAP Test
☐ Eye Infections	☐ Numbness/Tingling Sensations	☐ Vision - Failing	☐ Normal ☐ Abnormal
☐ Fatigue - Chronic	☐ Osteoporosis	☐ Weight Loss	Date of Last Mammogram
☐ Foot Pain ☐ Cold Numb Feet	☐ Phobias		☐ Normal ☐ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	Migraine	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐	Other:						
Heart Disease	☐	☐	☐	☐	☐	☐	Other:						

Habits

☐ Alcohol: Type Amount per week:	☐ Diet: Good( ) Fair( ) Poor( ) Salt Intake: High( ) Low( ) Fat Intake: High( ) Low( )	☐ Sleep: Difficulty Falling Asleep Sometimes( ) Always( ) Insomnia: Yes( ) No( ) Daytime Somnolence: Yes / No	☐ Smoke: Packs Daily How many years: Interested in stopping? Yes / No
☐ Coffee: Cups per day Marijuana/ Other Drugs: Yes / No	☐ Exercise: Yes( ) No( ) Frequency: Daily( ) Weekly( )	Chronic Fatigue: Yes / No Other:	

Comments: