

TULSA HEALTH GROUP - STEVEN WISEMAN, M.D.
MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE _____

AGE: _____ SEX: _____ MARITAL STATUS: _____ OCCUPATION: _____

PERSONAL & FAMILY HISTORY

Circle Yes (Y) or No (N) to indicate whether you or anyone in your family has (or has ever had) any of the following conditions. If a member of your family has had one of these conditions, please indicate the relationship.

DESCRIPTION	PERSONAL	FAMILY	RELATION	DESCRIPTION	PERSONAL	FAMILY	RELATION
Hearing problems	Y N	Y N		High cholesterol	Y N	Y N	
Heart disease	Y N	Y N		Epilepsy or seizures	Y N	Y N	
High blood pressure	Y N	Y N		Migraine headaches	Y N	Y N	
Stroke	Y N	Y N		Arthritis or gout	Y N	Y N	
Asthma, emphysema, bronchitis	Y N	Y N		Depression/nervous problem	Y N	Y N	
Ulcers	Y N	Y N		Diabetes	Y N	Y N	
Cancer:	Y N	Y N		Hepatitis or liver problems	Y N	Y N	
Breast	Y N	Y N		Thyroid disease	Y N	Y N	
Colon	Y N	Y N		Abnormal bleeding	Y N	Y N	
Prostate	Y N	Y N		Anemia	Y N	Y N	
Other (Where?)	Y N	Y N		Polio	Y N	Y N	
Kidney stones	Y N	Y N		Tuberculosis	Y N	Y N	
Gallbladder	Y N	Y N					

SOCIAL HISTORY Please indicate your usage of:

Cigarettes: Yes ___ No ___ Packs per day ___ For how many years? ___ Date quit? ___
 Alcoholic beverages: Yes ___ No ___ How many drinks per week? ___ How many drinks per month? ___
 Caffeinated beverages: Yes ___ No ___ Cups of coffee per day ___ Soft drinks/tea per day ___
 Total number of children in home: _____

HOSPITALIZATIONS/SURGERIES Please list all previous hospitalizations and/or surgeries (inpatient and outpatient):

HOSPITALIZATION	DATE	HOSPITALIZATION	DATE

MEDICATIONS Please list prescription or over-the-counter medications and dosage that you are currently using.

MEDICATION NAME/DOSAGE	MEDICATION NAME/DOSAGE	MEDICATION NAME/DOSAGE

Are you allergic to any medications? Yes ___ No ___ If yes, which ones? _____

IMMUNIZATIONS

TYPE OF IMMUNIZATION	DATE	OTHER IMMUNIZATIONS	DATE
Last Pneumonia			
Last Tetanus			
Last Influenza			
Last TB Skin Test			

REVIEW OF SYSTEMS: Review the list below. Check each item (Yes or No) to show if you now have or have recently had any of these problems. If you need help with this form, our staff will be happy to assist you.

<u> </u>	<u> </u>	Weight change in past year <u> </u> loss <u> </u> gain	<u> </u>	<u> </u>	Pus, blood or milky color urine
<u> </u>	<u> </u>	Chronic tiredness or weakness	<u> </u>	<u> </u>	Reduction in force or stream or urine
<u> </u>	<u> </u>	Continuous fever for more than 5 days	<u> </u>	<u> </u>	Difficulty starting urine stream
<u> </u>	<u> </u>	Loss of appetite	<u> </u>	<u> </u>	Leakage of urine
<u> </u>	<u> </u>	Paleness of the skin	<u> </u>	<u> </u>	Back pain <u> </u> low <u> </u> high
<u> </u>	<u> </u>	Prefer <u> </u> hot weather or <u> </u> cold weather	<u> </u>	<u> </u>	Muscle cramps in arms, legs, hands or feet
<u> </u>	<u> </u>	<u> </u> Loss or <u> </u> increase in hair growth	<u> </u>	<u> </u>	Pain in legs while walking
<u> </u>	<u> </u>	Dry skin or skin rash	<u> </u>	<u> </u>	Pain or swelling of joints
<u> </u>	<u> </u>	Hives or itching of the skin	<u> </u>	<u> </u>	Pain in hands or feet in cold weather
<u> </u>	<u> </u>	Excessive blistering after exposure to the sun	<u> </u>	<u> </u>	Numbness, tingling or weakness in
<u> </u>	<u> </u>	Difficulty seeing or double vision	<u> </u>	<u> </u>	<u> </u> hands <u> </u> feet <u> </u> arms <u> </u> legs
<u> </u>	<u> </u>	Difficulty with hearing	<u> </u>	<u> </u>	Difficulty maintaining balance
<u> </u>	<u> </u>	ringing in the ears	<u> </u>	<u> </u>	Dizziness, fainting or blackout spells
<u> </u>	<u> </u>	Difficulty smelling things	<u> </u>	<u> </u>	Headaches <u> </u> Frequent? <u> </u> Severe?
<u> </u>	<u> </u>	Excessive sneezing	<u> </u>	<u> </u>	Problem with thinking clearly
<u> </u>	<u> </u>	Trouble breathing through nose	<u> </u>	<u> </u>	Difficulty with memory
<u> </u>	<u> </u>	Change in voice	<u> </u>	<u> </u>	Crying spells, depression or anxiety
<u> </u>	<u> </u>	Shortness of breath <u> </u> walking <u> </u> at rest	<u> </u>	<u> </u>	Mood swings or nervousness
<u> </u>	<u> </u>	Nose bleeds	<u> </u>	<u> </u>	Insomnia (difficulty sleeping)
<u> </u>	<u> </u>	Swelling of <u> </u> feet <u> </u> ankles <u> </u> legs	<u> </u>	<u> </u>	Jaundice (yellow skin)
<u> </u>	<u> </u>	Palpitations or irregular heart beats	<u> </u>	<u> </u>	Excessive bleeding after cutting skin
<u> </u>	<u> </u>	Pain or tightness in chest	<u> </u>	<u> </u>	Easy bruising
<u> </u>	<u> </u>	Night sweats	<u> </u>	<u> </u>	Frequent infections
<u> </u>	<u> </u>	Chronic cough			<u>FOR WOMEN ONLY</u>
<u> </u>	<u> </u>	Coughing up blood	<u> </u>	<u> </u>	Lumps in breast or painful breasts
<u> </u>	<u> </u>	Wheezing during breathing	<u> </u>	<u> </u>	Painful or irregular periods
<u> </u>	<u> </u>	Chronic nausea or vomiting	<u> </u>	<u> </u>	Bleeding between periods
<u> </u>	<u> </u>	Trouble swallowing	<u> </u>	<u> </u>	Vaginal discharge
<u> </u>	<u> </u>	Chronic diarrhea	<u> </u>	<u> </u>	Age you began menstruation <u> </u>
<u> </u>	<u> </u>	Chronic constipation			How long do your periods last? <u> </u>
<u> </u>	<u> </u>	Black, loose stool movements			Date of last period <u> </u>
<u> </u>	<u> </u>	Blood in stool or vomit			
<u> </u>	<u> </u>	Stomach pain			<u>FOR MEN ONLY</u>
<u> </u>	<u> </u>	Hemorrhoids	<u> </u>	<u> </u>	Difficulty with erection
<u> </u>	<u> </u>	Frequent urination	<u> </u>	<u> </u>	Difficulty with ejaculation
<u> </u>	<u> </u>	Urination at night	<u> </u>	<u> </u>	Discharge from penis
<u> </u>	<u> </u>	Pain during urination	<u> </u>	<u> </u>	

Physician Review: _____ **Date:** _____

**UPDATE TO MEDICAL PROFILE/ROS
(For Clinic Use Only)**
