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Manzanita Medical**

Your Medical History Form

Name: _____ Date of Birth: _____

Occupation: _____ Main Problem: _____

Your Medical History:

Medical Illnesses/Injuries

Condition	Year	<u>Prior Surgery</u> Operation	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List All Medications You Take:

Medication	Dose	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Ongoing Medical Problems:

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Vomit Blood | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Palpitations/Rapid Heart Action | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hiatus Hernia/Ulcer | <input type="checkbox"/> Weakness/Numbness |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Abdominal Pain/Cramps | <input type="checkbox"/> Mouth Sores |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hives |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Skin/Hair Problems |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bruising/Bleeding |
| <input type="checkbox"/> Leg Cramps/Poor Circulation | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Blood Clots/Phlebitis |
| <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Sour Taste | <input type="checkbox"/> Itch | <input type="checkbox"/> Anemia/Iron |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Joint /Bone Pain |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Smoker (ever) |
| <input type="checkbox"/> Hoarse Voice | <input type="checkbox"/> Menstrual/Breast Problems | <input type="checkbox"/> Alcohol/Drug Use |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Thirst | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Thyroid Problems/Goitre | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stop Breathing at Night | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Sleepiness/Insomnia | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Ear/Sinus Problems |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Always Cold/Warm | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Pain | <input type="checkbox"/> Nutrition Problem |

Family Medical History

Please check if any blood relative has or has had the following conditions:

Condition	Relation	Condition	Relation
<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Blood Pressure	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Cholesterol	_____	<input type="checkbox"/> Bleeding	_____
<input type="checkbox"/> Aneurysm	_____	<input type="checkbox"/> Blood Clots	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Thyroid	_____	<input type="checkbox"/> Other Illness	_____
<input type="checkbox"/> Anesthesia Problem	_____		

Have you ever had:

Date(s):

- | | | | |
|--|-------|--|-------|
| <input type="checkbox"/> Stress Test | _____ | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> MIBI | _____ | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Angiogram | _____ | <input type="checkbox"/> Blood Transfusion | _____ |
| <input type="checkbox"/> Angioplasty | _____ | <input type="checkbox"/> Enlarged Heart | _____ |
| <input type="checkbox"/> Bypass | _____ | <input type="checkbox"/> Heart Failure | _____ |
| <input type="checkbox"/> Echo | _____ | <input type="checkbox"/> Colitis | _____ |
| <input type="checkbox"/> ECG (last one) | _____ | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Chest X-ray(last one) | _____ | <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Mammogram | _____ | <input type="checkbox"/> Tetanus Shot | _____ |
| <input type="checkbox"/> CT Scan/MRI | _____ | <input type="checkbox"/> Pneumonia Shot | _____ |
| | | <input type="checkbox"/> Hepatitis Shot | _____ |

Other Questions:

- Marital Status _____
Children (#/ages) _____
Education _____
Pets _____
Hobbies _____
Exercise _____
Foreign Travel _____
Stress Level _____
Alternative Remedy Use _____
Favorite Movie _____

Signature _____

Date _____