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.

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

Physician Review: _____ **Date:**_____

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

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