GREYSTONE MEDICAL CLINIC

PATIENT HISTORY

Last Name:	First Name:	Middle Initial:	Date:

Age	Birthdate	Married □	Single □	Widow(er) □	Divorced □

Occupation?	Referred by?

SYMPTOMS Check (√) symptoms you currently have now or have had in the past year.

GENERAL: □ fever □ chills □ appetite change □ fatigue □ night sweats □ insomnia

HEAD: □ trauma □ headache □ dizziness

EARS: □ hearing changes □ ringing in ears □ pain □ discharge □ vertigo

EYES: □ vision changes □ sensitivity to light □ blurred vision □ double vision □ drainage

NOSE: □ sinus congestion □ nose bleeds □ polyps

THROAT: □ hoarseness □ sore throat □ tooth loss

CHEST: □ cough □ shortness of breath □ pneumonia □ wheezing □ coughing up blood

CARDIAC: □ chest pain □ shortness of breath with exertion □ palpitations □ edema

ABDOMEN: □ heartburn □ nausea □ vomiting □ indigestion □ pain □ diarrhea □ constipation □ rectal bleeding

URINARY TRACT: □ urgency □ frequency □ hesitancy □ blood in urine □ incontinence

NEUROLOGICAL: □ tremors □ fainting □ seizures □ numbness □ tingling □ confusion

PSYCHOLOGICAL: □ depression □ anxiety □ suicidal thoughts

MUSCULOSKELETAL: □ arthritis □ trauma □ joint swelling

ENDOCRINE: □ excessive thirst □ hot/cold intolerance □ reduced libido □ irregular periods □ change in skin pigmentation

CONDITIONS Check (√) conditions you have or have had in the past.

□ Anemia	□ Chicken Pox	□ Migraine headaches
□ Anorexia	□ Depression	□ Multiple Sclerosis
□ Appendicitis	□ Diabetes	□ Pneumonia
□ Arthritis	□ Emphysema	□ Stroke
□ Asthma	□ Epilepsy	□ Thyroid problems
□ Back pain/injury	□ Glaucoma	□ Tonsillitis
□ Bleeding disorder	□ Gout	□ Tuberculosis
□ Breast lump	□ Heart disease	□ Venereal disease
□ Bronchitis	□ Hepatitis	Date of last tetanus shot:
□ Cancer	□ Hernia	
□ Cataracts	□ High cholesterol	

Family History

Illness/Condition	**Family Member**								
	grandfather	grandmother	father	mother	brother	sister	son	daughter	other
Asthma									
Bleeding disorder									
Cancer									
Diabetes									
Glaucoma									
Heart disease									
High blood pressure									
Depression									
Stroke									
Other									

MEDICATIONS		
Prescription Medications	**Dosage**	**How often taken**

Non-Prescription Medications		
Over the counter medications	**Dosage**	**How often taken**

SURGERIES		
Year	**Surgical Procedure**	**Reason**

OTHER ILLNESSES /ACCIDENTS: Include car/motorcycle/4-wheeler, etc.		
Year	Serious illness/Injuries	Outcome

ALLERGIES OR DRUG REACTIONS? Please list drug and type of reaction.

HABITS

Do you smoke? □ Yes □ No If yes , how many packs per day? If quit, how long ago?

Do you use alcohol? □ Yes □ No If yes, how often do you drink?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature of Patient / Guardian Date