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MEDICAL HISTORY

Patient Name Today’s Date Date of Birth Sex  Male  Female

Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner Race:  American Indian or Alaska Native  Asian  Black or African American

* Native Hawaiian or Other Pacific Islander  White Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Current Employment Status:  Full-time  Part-time  Retired  Unemployed  Student

Do you currently use any tobacco products?  Yes  No

If yes, what do you use:  Cigarettes  Cigars  Pipe  Smokeless Other: If yes, amount of use per day:

Do you currently drink alcoholic beverages?  Yes  No

If yes, how often:  Daily  Weekly  Monthly  Occasionally  Rarely

Do you currently use recreational drugs?  Yes  No

If yes, what drugs: How often:  Daily  Weekly  Monthly  Occasionally  Rarely

Current Medications

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| --- | --- | --- | --- |
| Drug Name Dosage (mg) Frequency (how often) Route (into body) | | | |
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Allergies (foods, medications, plastics, etc.):

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence:

Have you been immunized?  Yes  No

If yes, for what illness or diseases:

Have you experienced any of the following major medical conditions (please check all that apply):

* AIDS/HIV
* Arthritis
* Blood Disorders
* Cancer
* Chicken Pox
* Depression
* Diabetes
* Diphtheria
* Encephalitis
* Fatigue
* Genetic Disorders
* Headaches
* Head Injury
* Heart Problems
* High Blood Pressure
* High Fevers
* Influenza
* Malaise
* Malaria
* Measles
* Meningitis
* Mumps
* Scarlet Fever
* Stroke
* TMJ
* Typhoid
* Vascular Problems
* Other

|  |  |  |
| --- | --- | --- |
| Please check the correct box for the following medical symptoms or conditions: |  | |
| Eye problems (such as blurred or double vision, pain): | * Yes | * No |
| Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues): | * Yes | * No |
| Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations): | * Yes | * No |
| Respiratory issues (such as shortness of breath, cough, wheezing): | * Yes | * No |
| Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain): | * Yes | * No |
| Musculoskeletal issues (such as joint pain, swelling, recent trauma): | * Yes | * No |
| Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness): | * Yes | * No |
| Psychiatric issues (such as depression, anxiety, compulsions): | * Yes | * No |
| Endocrine symptoms (such as frequent urination, hot flashes): | * Yes | * No |
| Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands): | * Yes | * No |
| Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency): | * Yes | * No |

Comments related to review of symptoms above: