

Matthew W. Bradley, M.D.

Medical History Form

PLEASE PRINT LEGIBLY

Patient Name: _____ Date: _____

Past Medical History:

Hypertension (high blood pressure)	Y	N	Elevated Cholesterol	Y	N
Arthritis	Y	N	Diabetes	Y	N
Heart Disease	Y	N	Cancer	Y	N
Gastric Bypass Surgery	Y	N	Lung Disease	Y	N
Jewelry Reaction	Y	N	Metal Reaction	Y	N

Other: _____

ALL Allergies and Adverse Reactions: (If NO allergies please list NONE)

Medications:	Name	Dosage	Name	Dosage
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Past Surgical History: (please indicate each procedure and year performed)

Social History:

Do you smoke? Y / N Packs/Day _____

Alcohol use Y / N : Moderate / Occasionally / Daily / Socially / Rarely / Never

Do you have any history of alcoholism or substance abuse? Y / N

Marital Status (please circle): Single Married Divorced Widow

Employment status: (please list/describe job if employed). _____

Family History:

Hypertension	Mother	Father	Sibling	Grandparent
Cancer	Mother	Father	Sibling	Grandparent
Diabetes	Mother	Father	Sibling	Grandparent
Arthritis	Mother	Father	Sibling	Grandparent
Heart Disease	Mother	Father	Sibling	Grandparent

Other: _____

Review of Systems:

Do you wear corrective lenses? (glasses, contacts)	Y	N
Do you suffer from Frequent headaches?	Y	N
Dizziness?	Y	N
Shortness of breath?	Y	N
Episodes of chest pain?	Y	N
Heartburn?	Y	N
Numbness or tingling in extremities?	Y	N
Chronic joint or muscle aches?	Y	N
Have you been diagnosed with liver or kidney disorders?	Y	N

Patient Signature _____ Date _____