Confidential Health History **Judith L. Thompson, M.D.**

NAME:	**DATE OF BIRTH:**	**Age:**
PRIMARY MD		
Why are you here today:		
Description of symptoms:		
SOCIAL HISTORY		
Do you smoke? ❑ Yes ❑ No How much?		
Do you drink alcohol? ❑ Yes ❑ No How much?		
Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed		
Children ❑Yes How many? ❑No Type of Work?		
Drug Allergies:		
SURGERY HISTORY		
Surgery		Date:
Surgery		Date:
Surgery		Date:
MEDICAL HISTORY		

FAMILY HISTORY				
Health Status or cause of death/Father/Age				
Health Status or cause of death/Mother/Age				
Any diseases/bleeding disorders in your family? ❑ Yes ❑ No Describe:				
Has any family member had complications from anesthesia? Describe:				
REVIEW OF SYSTEMS: All systems will be considered negative unless checked below:_____				
General	**Cardiovascular**	**GU**	**Neurological**	**Endocrine**
❑ Chills	❑ Chest Pain	❑ Painful urination	❑ Headaches	❑ Change in hair
❑ Fever	❑ Ankle swelling	❑ Blood in urine	❑ Seizure	❑ Change in nails
❑ Weight gain	❑ Palpitations	❑ Leaking urine	❑ Syncope	❑ Goiter
❑ Weight loss	❑ Shortness of breath	❑ Night urination	**Mental Health**	❑ Heat intolerance
❑ Fatigue	❑Shortness of breath lying down	❑Urinating Frequency	❑ Anxiety	❑ Cold intolerance
❑ Feeling poorly	**Musculoskeletal**	**Gastrointestinal**	❑ Changes in memory	❑ Excessive drinking
Head & Neck	❑ Swelling	❑ Diarrhea	❑ Changes in sleep	❑ Excessive urination
❑ Neck Pain	❑ Stiffness	❑ Difficulty swallowing	❑ Depression	**Respiratory**
❑ Voice change	❑ Joint Pain	❑ Abdominal pain	**Hematologic/lymph**	❑ Cough
❑ Growths		❑ Black/tarry stools	❑ Anemia	❑ Wheezing
Skin		❑ Nausea/vomiting	❑ Bleeding Tendency	❑ Shortness of breath
❑ Dryness		❑ Rectal Bleeding	❑ Bruising	❑ Chest pain
❑ Itching		❑ Reflux	❑ Lymph Node enlargement	
❑ Rash		❑Change in intestinal pattern		
Signature:			**Date:**	