

Dr. Michael D. Sheps

MEDICAL HISTORY

Name: First _____ Last _____ Date _____

Physical Problem _____

Date of Onset and Cause _____

Previous Surgeries and Dates _____

Current Medications and Purpose _____

Drug Allergies and Reaction _____

Family History of Major Illnesses _____

Social History: Smoking _____ Alcohol Abuse _____ Drug Abuse _____

Current or Past Medical Illnesses (List condition related to system and any explanation):

Skin _____ Gynecological _____

Eyes _____ Neurological _____

Ear, Nose, Throat _____ Psychiatric _____

Respiratory _____ Hematological _____

Cardiovascular _____ Endocrine _____

Gastrointestinal _____ Immune _____

Genitourinary _____ Musculoskeletal _____