DYSAUTONOMIA-MVP CENTER, LLC
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PATIENT MEDICAL HISTORY FORM

Patient Name (legal): _____
Date of Birth: _____ Age: _____ Today's Date: _____
Pharmacy Name: _____ Pharmacy Tel Number: _____
Referring Physician: _____
Primary Care Physician: _____
Do you want a copy of our doctor's note to be sent to your referring / primary care doctor? Yes / No
Main reason you are here to see the doctor: _____

Please circle any of the following conditions you currently experience:
Chills / fatigue / fever / sleep disturbance / weight loss
Blurred vision / dry eyes
Hearing loss / ringing in the ears / sore throat
Goiter / hair loss / irregular periods (female) / low testosterone (males) / diabetes
Cough / shortness of breath / wheezing
Swelling in any extremities / fainting/ lightheadedness / chest pain / palpitations
Abdominal pain, bloating or cramping / irritable bowel syndrome / constipation / diarrhea / nausea / vomiting
Cancer / blood clots: if yes, where: _____ / easy bruising
Pain during urination / excessive urination / incontinence / kidney stones / urinary tract infection / kidney problems
Muscle aches / joint pain / muscle cramps / broken bones / joint dislocation
Hives / itching / rash
Migraines / numbness / vertigo / headache/ tics / tingling / numbness / tremor
Psychiatric meds in the past: yes / no
Anxiety, depression

Past Medical History:
Have you been diagnosed with any of the following: If yes, please explain:
Cancer: Yes / No _____
High blood pressure: Yes / No _____
Diabetes: Yes / No _____
Heart problems: Yes/ No _____
Mental / nervous conditions: Yes/ No _____
Other: _____

Past Surgical History:
Please list any surgeries you have had in the past:

Date	Type of Surgery	Surgeon (if known)

Past Hospitalization:

Please list any hospitalizations other than for surgeries already listed:

Reason	Date

Family History:	Type	
Cancer		Mother / Father / Sister / Brother
Heart disease		Mother / Father / Sister / Brother
Diabetes		Mother / Father / Sister / Brother
Mental conditions		Mother / Father / Sister / Brother
Thyroid disorder		Mother / Father / Sister / Brother
Other		

Social History:

Marital Status: Single / Married / Divorced / Separated / Widowed

Children: Yes : how many _____ / Ages: _____

Smoking Status: Do you smoke: Yes / No If yes : cigarettes / cigars / chewing tobacco

How much do you smoke? _____ / day; _____/ week

Alcohol: Do you drink alcohol: Yes / No

If yes, how much: _____ drinks per day ; _____ drinks per week

Caffeine intake: Yes / No

If yes: _____ cups coffee / tea per day

Carbonated caffeine beverages: _____ / day

Fluid intake: How much fluid do you drink per day?

_____ / cups or oz

Exercise history: Do you exercise: Yes / No

If yes, how much: _____ / day ; _____ / week

Do you get allergy shots: Yes / No Do you have asthma? Yes / No

Medications:

Are you allergic to any medications: Yes / No

If yes, please list: _____

Please list your current medications:

Medication name	Dose	How often	Why do you take this	Who prescribes this

Patient signature: _____ Date: _____

Physician signature: _____ Date: _____