www.TheAlpineClinic.com

The Alpine Clinic, PLLC

A division of Littleton Regional Healthcare

MEDICAL HISTORY

NAME:_____ DOB:_____ DATE:_____

HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____

Current Medications		
NAME	DOSAGE	FREQUENCY

Past Surgeries	
DATE	DESCRIPTION

Allergies

_____

_____

_____

Medical Symptoms Today (check all that apply):

- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Numbness
- ☐ Tingling
- ☐ Hearing Loss
- ☐ Vision Loss
- ☐ Headaches
- ☐ Blurry Vision
- ☐ Difficulty Swallowing
- ☐ Ringing in Ears
- ☐ Upper Respiratory Infection
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Skipping Heartbeat
- ☐ Shortness of breath
- ☐ Trouble breathing
- ☐ Cough
- ☐ Sputum
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Reflux/Heartburn
- ☐ Itching (urinal)
- ☐ Burning (urinal)
- ☐ Hesitancy (urinal)
- ☐ Frequency (urinal)
- ☐ Foul odor (urinal)
- ☐ Change in mood
- ☐ Depression
- ☐ Anxiety

Past and Current Medical Problems (check all that apply):

- ☐ Arthritis/Joint Pain
- ☐ Asthma/Wheezing
- ☐ Clotting Problem
- ☐ Cancer/Tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV (positive for AIDS)
- ☐ Limited Neck Motion
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcers
- ☐ Other:

Tobacco Use: ☐ NO ☐ YES
Type:_____
Number of years: _____
Packs per day:_____
Year quit:_____

Alcohol Use: ☐ NO ☐ YES
Type:_____
Frequency:_____
Year quit:_____

Hobbies/Sports

_____

_____

_____

Do you have access to exercise equipment? ☐ NO ☐ YES

Family History (please check all that apply):						
	MOTHER	FATHER	MOTHER'S MOTHER	MOTHER'S FATHER	FATHER'S MOTHER	FATHER'S FATHER
Heart Attack						
High Cholesterol						
High Blood Pressure						
Arthritis/Osteoarthritis						
Rheumatoid Arthritis						
Diabetes						
Bleeding/Clotting Problems						
Osteoporosis						