

CAROL L. PIATT, M.D.
MEDICAL HISTORY FORM

Name: _____ **DOB:** _____ **Birthplace:** _____

Education: *(circle one)* High School College Post-Graduate

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

To the best of my knowledge, the questions on the form have been answered accurately. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the health care services that I (my child) may need.

Patient Signature: _____

Please circle any of the following that you have or you have had within the last year:

Frequent or severe headaches	Change in bowel movements	Hay Fever
Tiredness	Dry skin	Fainting spells
Dizziness on change of position	Strange taste or loss of taste	Palpitations
Unconscious spells	Persistent hoarseness	Hypertension
Blurred or double vision	Difficulty swallowing	Stomach pain
Spots before eyes	Change in hair texture	Leg cramps
Infected or painful eyes	Recurrent sore throats	Chest Pain
Tuberculosis	Recurrent sores in mouth	Enlarged glands
Any change in vision	Sore or bleeding gums	Angina pectoris
Diabetes	Enlarged veins in legs	Heartburn
Change in skin color	Swelling of hands and feet	Appetite Change
Brittleness of nails	Coughed up blood	Night sweats
Ringing in the ears	Pain in arm(s)	Vomited blood
Decrease in hearing	Nausea or vomiting	Rectal bleeding
Recurrent nose bleeds	Chronic or frequent cough	Easy bruising
Recurrent head colds	Shortness of breath	Sinus trouble
Change in skin texture	Purple fingers or lips	Earaches

Smoker – Y / N

If yes, how many per day? _____

Has any blood relative ever had the following:

Skin Cancer	Tuberculosis	Diabetes
Heart Trouble	Hypertension	Other Cancer