Dr. Khaldoun Al-Rayess, M.D. and Brett Rawlins, F.N.P
Medical History Form

Name: _____ Date of Birth: _____

Referring Doctor: _____ Primary Care Doctor: _____

Allergies: _____

_____

Medications (name, dose, frequency) 1. _____

2. _____ 3. _____

4. _____ 5. _____

6. _____ 7. _____

8. _____ 9. _____

10. _____ 11. _____

12. _____ 13. _____

Surgeries: _____

_____

Past Medical History

Have you had the following?

Diabetes	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
Kidney Disease	Yes	No
Vision Problems	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Thyroid Problems	Yes	No
Kidney Stones	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Osteoporosis	Yes	No

Family History

Has any blood relative had the following? If so, who has it, and how often?

Thyroid	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Osteoporosis	Yes	No
Strokes	Yes	No

Social History

Work	Yes	No
Smoke	Yes	No
Consume Alcohol	Yes	No
Drugs	Yes	No

TANNER CLINIC

Review of Systems

☐	Weight Loss	☐	Abdominal Pain	☐	Hair Loss
☐	Weight Gain	☐	Diarrhea	☐	Acne
☐	Fatigue	☐	Constipation	☐	Headache
☐	Fever	☐	Night Sweats	☐	Dizziness
☐	Insomnia	☐	Swelling Extremities	☐	Palpitations
☐	Chest Pain	☐	Depression	☐	Heat Sensitivity
☐	Shortness of Breath	☐	Irregular Periods	☐	Cold Sensitivity
☐	Cough	☐	Hair Growth		