DR. PAULA D. MOORE
DYSAUTONOMIA CENTER

2470 ROCKY RIDGE RD, STE 200
BIRMINGHAM, AL 35243
P: (205) 286-3200
F: (205) 823-2465

PATIENT MEDICAL HISTORY FORM

Patient Name (legal): _____

Date of Birth: _____ Age: _____ Today's Date: _____

Pharmacy Name: _____ Pharmacy Tel Number: _____

Referring Physician: _____ Primary Physician: _____

Email address: _____ Occupation: _____

Current Medications

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

Do you get allergy shots? Yes / No

Are you allergic to any medications? Yes / No

If yes, please list them: _____

_____

Past Medical History: Please check beside any of the conditions that you HAVE BEEN diagnosed with and/or treated for					
Heart Disease		Lung Disease		Epilepsy or Seizures	
High Blood Pressure		Asthma		Irritable Bowel Syndrome	
High Cholesterol		Seasonal Allergies		Gastroparesis	
Mitral Valve Prolapse		Arthritis		Reflux	
Diabetes		Fibromyalgia		Vein Trouble	
Kidney Problems		Osteoporosis		Meniere's or Vertigo	
Thyroid Problems		Ehlers-Danlos Syndrome		Insomnia	
Shortness of Breath		Anemia		Narcolepsy	
Nervous Disorder		Stroke		Cancer	
Migraines		COVID-19		If yes, which type? _____	

Other Medical Conditions (please list): _____

_____

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					
Medical Condition	**Type**	**Mother**	**Father**	**Sister(s)**	**Brother(s)**
Cancer					
Heart Disease					
Diabetes					
Mental Conditions					
Thyroid Disorder					

List any other pertinent family medical history: _____
_____

- Is your mother alive? Yes / No (age at death: ____ ; cause: _____)
- Is your father alive? Yes / No (age at death: ____ ; cause: _____)

Social History:

Marital Status:	Single / Married / Divorced / Separated / Widowed
Children:	Yes / No; If yes, how many _____ / Year of birth of each: _____
Smoking Status:	Do you smoke or use tobacco: Yes / No; If yes: cigarettes / cigars / chewing tobacco / vape
	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: _____minutes / day; _____days / week

Please circle any of the following conditions you CURRENTLY experience:

Allergies / Insomnia / Sleep apnea / Narcolepsy / Excessive sleepiness / Personal Cancer history: if yes, where_____ / fatigue /weight loss
Vertigo / Hearing loss / Ringing in ears
Goiter / hypothyroidism / hyperthyroidism / diabetes: type I or II
Syncope (passing out) / Lightheadedness / Tachycardia (fast heart rate) / Heart attack / High cholesterol / Chest pain /High blood pressure / Palpitations / shortness of breath
Abdominal bloating / IBS / Abdominal pain / Constipation / Diarrhea
Pain in joints / Muscle pains / Fibromyalgia / Ehlers-Danlos Syndrome / Arthritis
Migraines / Dizziness / Tingling and numbness
Psychiatric meds in the past? Yes / No / Bipolar disorder / Anxiety / Depression
Asthma / cough / wheezing
Blurred vision / dry eyes / floaters in eyes

*** Patient signature: _____ Date: _____ ***

***** You must sign this form *****