



MEDICAL HISTORY

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Name: _____ Age: _____ Today's Date: _____

PURPOSE of visit (what part of the body): _____

WHEN (exact date) did symptoms begin? _____

WHERE (example: home, work)? _____

HOW did symptoms begin? _____

Have you seen another physician(s) for this problem? YES NO

If yes, please list names and approximate dates you were treated: _____

Family Doctor: _____

FOR WORK RELATED INJURY:

Injury Date: _____ Date reported to employer: _____

SOCIAL HISTORY:

Tobacco: YES NO Packages per day: _____ Number of years: _____

Alcohol: YES NO Social Heavy

MEDICATIONS:

Name	Dosage/Strength	Frequency

TESTS:

Have you had the following diagnostic tests performed during the past four months?

Tests	Date	Doctor	Result
Blood work			
Bone scan			
CT scan			
MRI scan			
Arteriogram			
Other			

DRUG ALLERGIES:

Name of Drug	Reaction

REVIEW OF SYSTEMS:

Have you recently had any of the following medical problems?

Problem	Yes	No	If Yes, Please Explain
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs, feet	<input type="checkbox"/>	<input type="checkbox"/>	
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>	

