

Medical History

Full name: _____	Date of birth: _____	Date: _____
Primary doctor: _____		
Doctor who requested today's visit: _____		
List current/previous doctors and their specialty: _____		

ALLERGIES AND REACTIONS _____ _____ _____	MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control) _____ _____ _____
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PAST MEDICAL ILLNESSES (please check if you have had the following):

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Alcohol/Drug addiction | <input type="checkbox"/> Cancer (type): | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Colon <input type="checkbox"/> Uterine | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> _____ | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sexually transmitted disease (type): | <input type="checkbox"/> (Positive) TB skin test |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hepatitis B or C | _____ | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Sleep apnea | _____ |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stomach ulcer | _____ |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | | _____ |

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY Adopted

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters	1) <input type="checkbox"/> M <input type="checkbox"/> F		
	2) <input type="checkbox"/> M <input type="checkbox"/> F		
	3) <input type="checkbox"/> M <input type="checkbox"/> F		
Sons and Daughters	1) <input type="checkbox"/> M <input type="checkbox"/> F		
	2) <input type="checkbox"/> M <input type="checkbox"/> F		
	3) <input type="checkbox"/> M <input type="checkbox"/> F		

SOCIAL HISTORY

Occupation: _____	Marital Status: _____	Children: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often? _____	How many drinks? _____
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Packs per day: <input type="checkbox"/> 1/4 pack <input type="checkbox"/> 1 1/2 packs	How many years? _____
Are you a former smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1/2 pack <input type="checkbox"/> 2 packs	Year quit? _____
Do you chew tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 pack <input type="checkbox"/> Other: _____	
Do you use recreational/illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you worked with asbestos or other hazardous materials? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Healthcare proxy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, who? _____
Advanced Directive for Healthcare _____		

HEALTH MAINTENANCE

Last menstrual period: _____ Last pap smear: _____ Last mammogram: _____

Last colonoscopy: _____ Last prostate cancer screening: _____ Last bone density scan: _____

Immunizations: Pneumovax: _____ Flu: _____ Tetanus: _____ Hep A: _____ Hep B: _____

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Trouble holding urine | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequency of urination | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in exercise tolerance | <input type="checkbox"/> Penis discharge | <input type="checkbox"/> Uncontrollable mood swings |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Vaginal discharge/bleeding | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Change in hearing | <input type="checkbox"/> Indigestion or heartburn | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Nausea | <input type="checkbox"/> Breast pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Nose bleed | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Feeling too hot | <input type="checkbox"/> Leg swelling |
| <input type="checkbox"/> Blood in sputum | <input type="checkbox"/> Change in bowel habit | <input type="checkbox"/> Feeling too cold | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Blood in vomit | <input type="checkbox"/> Dizziness | |

Please list all your reason(s) for visiting today in order of priority:

1. _____

2. _____

3. _____

_____ Patient/Designee signature	_____ Patient name (PRINT)	_____ Date	_____ Time
_____ Relationship to patient	_____ Reason patient is unable to sign		