

**PATIENT MEDICAL HISTORY FORM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ BIRTHDATE \_\_\_ / \_\_\_ / \_\_\_ AGE \_\_\_\_\_ GENDER  MALE  FEMALE

ALLERGIES TO MEDICATIONS, X-RAYS, DYES OR OTHER SUBSTANCES: \_\_\_\_\_

\_\_\_\_\_

NONE

**CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS, HERBS – PRESCRIPTION AND OVER-THE-COUNTER**

(LIST NAME AND DOSE):  NONE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Skin Diseases
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight loss/gain	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Low back problems	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Anemia	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Numbness of arms/legs	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Headache	<input type="checkbox"/> Depression
<input type="checkbox"/> Chest Pain/tightness	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Difficulty Passing urine	<input type="checkbox"/> Gout
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Difficulty holding urine	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Sleep problems	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Blood disorders		

**GYNECOLOGIC AND OBSTETRIC HISTORY: WOMEN ONLY**

Age at onset of periods: \_\_\_\_\_ Pregnancies: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_ Births: \_\_\_\_\_

Frequency: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

**OPERATIONS & HOSPITALIZATIONS (LIST YEAR AND TYPE OF OPERATION OR DIAGNOSES AFTER HOSPITALIZATION)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION HISTORY	YEAR	OTHER VACINES	YEAR
Last Tetanus Shot?	_____	Lyme Vaccine?	_____
Pneumovax Shot?	_____	Hepatitis A Vaccine?	_____
Flu Shot?	_____		
Hepatitis B Vaccine?	_____		

SCREENING TESTS (LAST ONE)	YEAR		YEAR
Mammogram?	_____	Breast exam?	_____
Pap Smear?	_____	Cholesterol Check?	_____
Stool check for blood?	_____	Prostate Exam?	_____

FAMILY HISTORY ILLNESS	GRAND FATHER	GRAND MOTHER	FATHER	MOTHER	BROTHER	SISTER	CHILD	AGES WHEN DIAGNOSED
	Cancer (type)							
Hypertension								
Diabetes								
Stroke								
Mental Disease (anxiety, depression)								
Drug or Alcohol addiction								
Glaucoma								
Bleeding diseases								
Other:								

PREVENTION			
Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Do you perform self breast exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Men: Do you perform self testicular exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke? Amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you following a specific diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink coffee? Amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, type of diet: _____	
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a gun in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use drugs? Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever engaged in any activity which would put you at risk of AIDS? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever worked with chemicals, paints, asbestos or other hazardous material? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No		