

MEDICAL HISTORY

NAME _____ DATE OF BIRTH _____ APPT DATE _____

FAMILY HISTORY IF ANY BLOOD RELATIVE (LIVING OR DECEASED) HAS SUFFERED ANY OF THE FOLLOWING - PLEASE WRITE MEDICAL PROBLEM(S) NEXT TO APPROPRIATE FAMILY MEMBER IN SPACE PROVIDED BELOW; INCLUDE AGE (IF LIVING) OR AGE AT TIME OF DEATH [e.g. 82(Dec)]

ALCOHOLISM	BLEEDS EASILY	GALL BLADDER	KIDNEY DISEASE	PARKINSONS	_____
ALLERGIES	CANCER (List Type)	GLAUCOMA	MALARIA	PSORIASIS	_____
ANEMIA	DIABETES	HAIR LOSS	MENTAL ILLNESS	STROKE	_____
ARTHRITIS	ECZEMA	HEART DISEASE	MIGRAINE	THYROID	_____
ASTHMA	EPILEPSY	HYPERTENSION	OSTEOPOROSIS	TUBERCULOSIS	_____

MATERNAL SIDE	AGE	PATERNAL SIDE	AGE
MOTHER		FATHER	
GRANDMOTHER		GRANDMOTHER	
GRANDFATHER		GRANDFATHER	
AUNT		AUNT	
UNCLE		UNCLE	
SISTER(S)		BROTHER(S)	
OTHERS		OTHERS	

FAMILY MEDICAL HISTORY (Add'l Notes)

HOSPITAL ADMISSIONS PLEASE LIST ANY HOSPITALIZATIONS OR SURGERIES YOU HAVE HAD; INCLUDE THE DIAGNOSIS (IF KNOWN) OR REASON FOR THE HOSPITALIZATION/SURGERY AND THE DATE

Not Including Pregnancies

	TYPE OF SURGERY/PROCEDURE AND DIAGNOSIS	DATE

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING	DRUG/MED ALLERGIES	TEST/EXAM	YR OF LAST (N/ABN)
		PHYSICAL EXAM:	
		VISION TEST:	
		PAP TEST:	
	VACCINES	MAMMOGRAM:	
	<input type="checkbox"/> TETANUS (Date)	BLOOD TEST:	
	<input type="checkbox"/> FLU (Date)	EKG:	
	<input type="checkbox"/> PNEUMONIA (Date)		

MEDICAL HISTORY

CURRENT COMPLAINTS 1) _____ 2) _____
 3) _____ 4) _____

CHECK (✓) AND INDICATE AGE YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES:

<input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular Pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold/ Numb Feet <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ear Infections-frequent <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Dizzy Spells/Fainting <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Infections-frequent <input type="checkbox"/> Vision ___ Failing ___ Double or Blurred <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throats-frequent <input type="checkbox"/> Hair Loss: ___ Progressive ___ Recent	<input type="checkbox"/> Bronchitis/Chronic Cough <input type="checkbox"/> Asthma/Wheezing <input type="checkbox"/> Shortness of Breath: ___ On Exertion ___ Lying Flat <input type="checkbox"/> Hayfever/Allergies <input type="checkbox"/> Hoarseness-Prolonged <input type="checkbox"/> Pneumonia/Pleurisy <input type="checkbox"/> Leg Pain-walking <input type="checkbox"/> Varicose Veins/Phelbitis <input type="checkbox"/> Loss of Appetite-recent <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Indigestion/Heartburn <input type="checkbox"/> Nausea/Vomiting-persistent <input type="checkbox"/> Peptic Ulcers <input type="checkbox"/> Abdominal Pain-chronic <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Jaundice/Hepatitis <input type="checkbox"/> Change in Bowel Habits: ___ Diarrhea ___ Constipation ___ Bloody/Tarry Stool	<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Bruise easily <input type="checkbox"/> Back Pain-recurrent <input type="checkbox"/> Bone Fracture/ Joint Injury <input type="checkbox"/> Weight Loss -recent <input type="checkbox"/> Weight Gain -recent <input type="checkbox"/> Rashes; ___ Hives <input type="checkbox"/> Psoriasis; ___ Eczema <input type="checkbox"/> Sleeping/ concentration-difficulty <input type="checkbox"/> Nervousness/Agitation <input type="checkbox"/> Depression <input type="checkbox"/> Memory Loss <input type="checkbox"/> Moodiness -excessive <input type="checkbox"/> Phobias <input type="checkbox"/> Mental Illness <input type="checkbox"/> Feelings of worthlessness	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Convulsions/Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor/Hands Shaking <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Headaches-frequent <input type="checkbox"/> Arthritis/Rheumatism <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Anemia <input type="checkbox"/> Urination: ___ Painful ___ Loss of Control ___ Decrease Force/Flow ___ Overnight >than twice ___ More than 8x / 24hrs ___ Urgency to urinate ___ Leakage	<p style="text-align: center;"><i>FEMALES-Please Complete</i></p> <input type="checkbox"/> Urine Infections-frequent <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Contact with Blood or Body Fluids <input type="checkbox"/> Aids/HIV <input type="checkbox"/> Alcohol ___ oz per week <input type="checkbox"/> Tobacco ___ cig per day ___ # years smoked <input type="checkbox"/> Coffee/Tea ___ cups per day <input type="checkbox"/> Acupuncture /Tattoos <input type="checkbox"/> Street Drugs	<input type="checkbox"/> Menstual Flow ___ Reg. ___ Irreg. ___ Pain/ Cramps ___ Days of Flow ___ Length of Cycle ___ Date-1st day last period <input type="checkbox"/> Pain/Bleeding during or after sex <input type="checkbox"/> Number of: ___ Pregnancies ___ Miscarriages ___ Abortions ___ Live Births Pregnant ___ Yes ___ No Pregnancy Plan ___ Yes ___ No Birth Control Method _____ B.C. Pill (name) _____ <input type="checkbox"/> Flushing/Menopause <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
--	--	--	---	--	--

USE SEPARATE SHEET FOR ADDITIONAL WRITING SPACE