Medical History Form

Name: (Last, First, Middle) ______________________ Date of Birth: ____________

Home Address: (Street) ______________________

____

Age: __________ Sex: □ Male □ Female

How do you rate your health: □ Excellent □ Good □ Fair □ Poor

Present Health Concerns: ______________________

____

____

Reason for your visit today (if same as above, write "Same"): ______________________

____

____

Current Medications: (Prescription and non-prescription durgs, vitamins, herbs, birth control, "patches". Please also include doses and how often medicine is taken)

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Allergies and Reaction to Medications:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Family History

	Living	Dead	Age	Chronic Conditions/Cause of Deat
Father				
Mother				
Sisters (# ______)				
Brothers (# ______)				

Social History:

Occupation ______________________

Exposure to chemicals/fumes/asbestos □ Currently □Past □Never

Smoking: □ Currently □Past □Never # of packs/day

Alcohol: □ Currently □Past □Never # of drinks/day

Other ______________________

With whom do you live? ______________________

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widow(er)

Past Surgical History	Why was surgery performed?	Date (year)

Past/Current Medical History

Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Anemia				Hepatitis			
Angina				Herpes infection			
Arthritis				High Blood Pressure			
Asthma				HIV infection			
Bleeding problems				Hyperthyroid (Overactive)			
Blindness				Hypothyroid (Underactive)			
Cancer (Type____________)				Kidney Stones			
Cataracts				Other Kidney disease			
Chicken Pox				Measles			
Chronic Bronchitis				Migraine or chronic HA			
Cirrhosis				Mumps			
Colon or bowel trouble				Phlebitis or Blood Clots			
Deafness				Polio			
Depression				Recurrent urinary infections			
Other psychiatric illness				Rheumatic fever			
Diabetes				Rubella			
Emphysema				Seizures or convulsions			
Enlarged heart or CHF				Sinusitis			
Gall stones				Skin problems			
Glaucoma				Stomach or Duodenal Ulcers			
Goiter				Stroke			
Gonorrhea				Syphilis or VD			
Gout				TB or positive TB test			
Hay fever, allergies				Other ____________			
Heart Attack				Other ____________			
Heart murmur							
Hemorrhoids							

Women's Health History

Date of last menstrual Period ____________ Concerns about Menopause? ☐Yes ☐ No

Age at time of first period? ____________ Age at time of last period? ____________

Duration of period? ____________ Frequency? ____________

History of Abnormal Pap smears? ☐Yes ☐ No

Are you sexually active? ☐Yes ☐ No Method of Contraception? ____________

Total # of pregnancies? ______ Deliveries? _ Miscarriages? ________ Abortions?____

Men's Health History?

Are you sexually active? ☐Yes ☐ No Method of Contraception? ____________

Erectile Dysfunction? ☐Yes ☐ No

Prostate problems? ☐Yes ☐ No

Review of Symptoms: (Please check mark in appropriate squares)

Constitutional/Endocrine	Present	Past	Never
Fever/Chills	☐	☐	☐
Excess weight loss/gain	☐	☐	☐
Weakness	☐	☐	☐
Loss of energy	☐	☐	☐
Excessive thirst	☐	☐	☐
Loss of appetite	☐	☐	☐
Change in Vision	☐	☐	☐

Pulmonary (Lungs)	Present	Past	Never
Difficulty breathing	☐	☐	☐
Chronic Cough	☐	☐	☐
Spit up blood	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Tuberculosis	☐	☐	☐
Other	☐	☐	☐

Musculoskeletal	Present	Past	Never
Muscle pain	☐	☐	☐
Joint Pain	☐	☐	☐
Limited joint movement	☐	☐	☐
Joint swelling	☐	☐	☐

Nervous system	Present	Past	Never
Loss of coordination	☐	☐	☐
Tingling sensation	☐	☐	☐
Numbness	☐	☐	☐
Paralysis	☐	☐	☐
Memory Loss	☐	☐	☐
Seizures	☐	☐	☐

Psychiatric	Present	Past	Never
Depressed mood	☐	☐	☐
Difficulty sleeping	☐	☐	☐
Decreased energy	☐	☐	☐

Cardiovascular	Present	Past	Never
Chest Pain/Discomfort	☐	☐	☐
Leg pain with exercise	☐	☐	☐
Palpitations	☐	☐	☐
"Skipped" heart beats	☐	☐	☐
Ankle swelling	☐	☐	☐
Easier to breathe sitting up	☐	☐	☐

Gastrointestinal	Present	Past	Never
Abdominal Pain	☐	☐	☐
Blood in stool	☐	☐	☐
Nauea/Vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Black Tarry Stools	☐	☐	☐
Vomiting blood	☐	☐	☐
Heartburn	☐	☐	☐
Constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐

Genitourinary	Present	Past	Never
Excess Urination	☐	☐	☐
Pain with urination	☐	☐	☐
"Leakage" of urine	☐	☐	☐
Frequent urination at night	☐	☐	☐
Difficulty initiating stream	☐	☐	☐
Blood in urine	☐	☐	☐
Genital discharge	☐	☐	☐
Difficulty achieving erection	☐	☐	☐

Breast	Present	Past	Never
Lumps or masses	☐	☐	☐
Nipple Dischareg	☐	☐	☐
Skin changes	☐	☐	☐

Other