PATIENT MEDICAL HISTORY (Part 1)

Full Name (Print): _____
Date of Birth: _____
Today's Date: _____

Please check NO or YES as applicable, if yes, give a brief description of problem.

NO	YES
( ) Weight change	( )
( ) Appetite change	( )
( ) Fever/Chills	( )
( ) Night Sweats	( )
( ) General Weakness	( )
( ) Dizziness, whirling, Or feeling faint	( )

ENDOCRINE SYSTEM

( ) Heat or Cold Intolerance	( )
( ) Thyroid Problems	( )
( ) History of Neck Surgery or irradiation	( )
( ) Increase in Thirst	( )
( ) Increase in Urination	( )

EYES

( ) Failing Vision/ Blind	( )
( ) Cataracts	( )
( ) Double Vision	( )
( ) Pain	( )
( ) Glasses	( )

EAR, NOSE, THOAT

( ) Difficulty Hearing/Deaf	( )
( ) Ringing in Ears	( )
( ) Nose Bleed	( )
( ) Hoarseness	( )
( ) Sinusitis	( )

GASTROINTESTINAL SYSTEM

( ) Nausea	( )
( ) Vomiting	( )
( ) Vomiting Blood	( )
( ) Difficulty in swallowing	( )
( ) Indigestion/ Heartburn	( )
( ) Abdominal Pain	( )
( ) Abdominal Swelling	( )
( ) Jaundice	( )
( ) Red Blood in Stool	( )

NO	YES
( ) Black Stool	( )
( ) Inability to Control Stool	( )
( ) Diarrhea	( )
( ) Constipation	( )
( ) Hemorrhoids	( )
( ) Hernia	( )
( ) Ulcer Disease History	( )
( ) Gall Bladder Disease History	( )
( ) Pancreatitis History	( )

LUNG

( ) Shortness of Breath	( )
( ) Shortness of Breath on Exertion	( )
( ) Sit up to Breathe	( )
( ) Get up after going to sleep To get breath	( )
( ) Cough now? How long?	( )
( ) Phlegm: Volume, Color, Odor, Viscosity	( )
( ) Cough Blood	( )
( ) Wheezing	( )
( ) Blueness in the Lip or Fingertips	( )
( ) Asthma History	( )
( ) Pneumonia History	( )
( ) History of Tuberculosis or Exposure to Tuberculosis	( )
( ) Skin Test for Tuberculosis Positive ( ) Negative ( )	( )
( ) Chest X-Ray in last year	( )
( ) History of Respiratory Infections, give frequency	( )

HEART & BLOOD VESSELS

( ) Chest Discomfort	( )
( ) Fainting Spells	( )
( ) Palpitations	( )
( ) Swelling of Ankles	( )
( ) Pain in Legs, Calves, or Feet While walking	( )
( ) Swelling or Pain in Calves	( )

PATIENT MEDICAL HISTORY (Part 2)

HEART & BLOOD VESSELS (continued)

NO	YES
( ) Hypertension History	( )
( ) Heart Murmur	( )
( ) Rheumatic Fever	( )

GU SYSTEM (GENERAL)

( ) Frequency passing Urine	( )
( ) Urgency in passing Urine	( )
( ) Pain in passing Urine	( )
( ) Abnormal Urine Color	( )
( ) Blood in Urine	( )

MALE GENITALIA

( ) Stream Size & Force decreased	( )
( ) Hesitancy	( )
( ) Inability to hold Urine (Stress, Urge, Dribbling) of Urine	( )
( ) History of Renal Disease or Stones	( )
( ) History of STD's	( )

FEMALE GENITALIA

( ) Vaginal Bleeding (not Menstrual)	( )
( ) History of STD's	( )

Last Menstrual Period: _____

NERVOUS SYSTEM

NO	YES
( ) Headaches	( )
( ) Loss of Consciousness	( )
( ) Seizures	( )
( ) Stroke History	( )

BLOOD

( ) Abnormal Bleeding / Bruising	( )
( ) Anemia	( )
( ) Transfusions	( )
( ) Family History of Sickle Cell	( )

MUSCULOSKELETAL SYSTEM

( ) Joint Stiffness	( )
( ) Joint Pain	( )
( ) Joint Swelling	( )
( ) Muscle Weakness	( )
( ) Backache	( )
( ) Neck Pain	( )

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PERSONAL INFORMATION

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____

Occupation: _____

MEDICAL HISTORY

Current Medications: _____

Current Health Problems:

Previous Health Problems:

ALLERGIES	
MEDICATION	OTHER THAN MEDICATION

HOSPITALIZATIONS

	Description	Year	Hospital
Illness: (kind)			
Surgery: (kind)			
Other: (reason)			

FAMILY HISTORY

	LIVING	DECEASED	IF DECEASED, PLEASE LIST CAUSE
FATHER	O	O	_____
MOTHER	O	O	_____
SIBLING'S	O	O	_____
	O	O	_____
	O	O	_____
	O	O	_____
CHILDREN	O	O	_____
	O	O	_____
	O	O	_____

IS THERE ANY FAMILY HISTORY OF:

	YES	NO	WHO?		YES	NO	WHO?
HEART DISEASE	O	O	_____	STROKE	O	O	_____
HYPERTENSION	O	O	_____	CANCER	O	O	_____
MENTAL DISORDER	O	O	_____	ALCOHOLISM	O	O	_____
DIABETES	O	O	_____	KIDNEY DISEASE	O	O	_____
BREAST CANCER	O	O	_____				

PERSONAL HABITS

	YES	NO	IF YES, HOW MUCH/HOW OFTEN?
DO YOU SMOKE?	O	O	_____
DO YOU CHEW TOBACCO?	O	O	_____
DO YOU DRINK ALCOHOL?	O	O	_____
DO YOU USE DRUGS?	O	O	_____
DO YOU EXERCISE REGULARLY?	O	O	_____

HAVE YOU HAD ANY
DEXA SCAN _____
COLONOSCOPY _____
ENDOSCOPY _____

FOR WOMEN ONLY

MENSTRUAL PERIODS _____
AGE ONSET _____
DATE OF LAST PERIOD _____
DIFFICULTY WITH PERIODS _____
SPECIFY _____
DO YOU USE BIRTH CONTROL PILLS? _____
DO YOU PRACTICE SELF BREAST EXAMINATIONS? _____
LUMPS OR DISCHARGE FROM BREASTS? _____

PREGNANCIES _____
LIVE BIRTHS _____ CAESARIAN _____
PREMATURE _____ MISCARRIAGES _____
DATE OF LAST PAP SMEAR _____
AGE OF MENOPAUSE _____

DATE OF LAST MAMMOGRAM _____