

Medical History

General Information

Name: _____ DOB: ___ / ___ / _____ Age: _____
 Social Security Number: ___ / ___ / _____ Sex: M F Date (today): ___ / ___ / _____
 Language(s) spoken: English Spanish Polish Other: _____

Medical History Check all current and past problems.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Dental/oral disease | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate disorder |
| <input type="checkbox"/> Anxiety problem | <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear/hearing problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin disease/sores |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Eye/vision problems | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Foot problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stomach/digestive disease |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Gall bladder disease/stones | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone/joint injuries | <input type="checkbox"/> Gastritis/ulcer | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis (or positive TB test) |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Headaches/migraine | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Urinary problem |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness | |
| <input type="checkbox"/> Dementia/memory loss | <input type="checkbox"/> Heart rhythm problem | <input type="checkbox"/> Osteoporosis | |
| | | <input type="checkbox"/> Overweight/obesity | |

Please give details of any items checked, or add information about other problems if they are not listed:

Surgical History List the date and type of any past surgeries.

Date	Surgery	Date	Surgery

Medications List your medications, prescription or non-prescription, including the dose and how often you take them. Please include all types of medicine, including pills, injections, creams and eye drops.

Medication	Dose and Frequency	Medication	Dose and Frequency

Are you taking or using anything else for your health or to treat symptoms (such as vitamins, herbs or weight loss products)? If so, please list them:

Allergies and Reactions

List any substances that have caused a bad reaction, and write the reaction.
Please include prescription or non-prescription medicines, foods, plants or other materials.

Substance	Reaction	Substance	Reaction

Personal History and Habits Your answers will be kept confidential.

General

Are you employed? Yes No If yes, what occupation?: _____
 Are you? Single Married Divorced Widowed
 Are you sexually active? Yes No
 Do you have children? Yes No If so, how old are they? _____
 Who lives with you in your home? _____
 At home, do you need help getting around, dressing, bathing, using the bathroom, or eating? Yes No
 If yes, what do you need help with? _____
 Do you exercise? Yes No If yes, what activities and how often? _____
 When was your last dental exam? _____ Do you wear dentures? Yes No
 When was your last vision exam? _____ Do you wear glasses or contact lenses? Yes No
 Have you recently or do you often travel outside the U.S.? Yes No If so, where? _____

Substances

Do you use tobacco? Yes No
 If no, have you ever used tobacco? Yes No
 If yes, what type: Cigarettes How much and for how long: _____
Cigars How much and for how long: _____
Chewing tobacco How much and for how long: _____

In the past year, have you ever drunk or used drugs more than you meant to? Yes No
 In the past year, have you ever thought you should cut down on your drinking or drug use? Yes No
 Do you ever get annoyed or angry when people talk to you about your drinking/drug use? Yes No
 Do you ever feel guilty about your drinking/drug use? Yes No
 Have you ever had an "eye-opener" (morning drink) to get started first thing in the morning? Yes No
 How many alcohol-containing drinks do you have in a typical week? (one drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor)
0 1-7 8-10 11-13 14-20 21-30 31-40 41 or more

Safety

Have you had any falls within the past 6 months? Yes No
 Do you use a cane, walker or other device to help you get around? Yes No
 Do you feel unsafe or threatened in any way (at home, work or otherwise)? Yes No
 Have you ever been the victim of violence or abuse (including sexual abuse)? Yes No
 Have you been hit, kicked or otherwise hurt by someone in the past year? Yes No
 Do you feel unsafe in your current relationship? Yes No
 Have you been forced to have sex? Yes No
 Do you or other family members keep gun(s) in the home? Yes No
 Do you wear a seatbelt when you drive? No Yes Sometimes
 Do you have smoke detector(s) in your home? No Yes Don't know

Nutrition

What is your usual weight? _____ What is your usual height? _____
 Have you had decreased food intake for more than one week? Yes No
 Have you unintentionally gained or lost 10 pounds in the last month? Yes No
 Do you have difficulty swallowing? Yes No
 Are you on a modified or special diet, or on tube feeding? Yes No
 (For **women**): Are you pregnant or breast-feeding? Yes No

Family History

Please write which family member(s) have or had the following:

Condition	Family Member(s)	Condition	Family Member(s)
Alcohol / substance abuse		High cholesterol	
Cancer, type: _____		Psychiatric illness	
Diabetes		Stroke	
Heart disease/attack		Tuberculosis	
High blood pressure		Other: _____	

Obstetric/Gynecologic History (for women only)

Age of first period? _____ If you no longer have periods, at what age did they stop? _____
 Please list: Total # of pregnancies? _____ Abortions? _____ Miscarriages? _____
 Do you plan to get pregnant within the next year? Yes No
 Are you using any birth control? Yes No If yes, what type? _____

Cancer Screening

Breast Cancer (for women only):

When was your last mammogram (year)? _____ Don't remember Never had one
 Have you ever had an abnormal mammogram? Yes No Don't know

Cervical Cancer (for women only):

When was your last Pap smear (year)? _____ Don't remember Never had one
 Have you ever had an abnormal Pap smear? Yes No Don't know

Colon cancer (for men and women over age 50):

Have you ever had a test to see if you had colon cancer? Yes No Don't know

Prostate cancer (for men only)

Have you ever had a rectal examination or a "PSA" blood test? Yes No Don't know

Immunizations Have you ever had the following vaccines?:

Tetanus: Yes, Year (most recent): _____ Never Don't know
 Flu: Yes, Year (most recent): _____ Never Don't know
 Pneumonia: Yes, Year (most recent): _____ Never Don't know

Advance Directives

Do you have a Living Will (instructions about the medical care you want given if you get very sick)? Yes No Don't know

Do you have a Power of Attorney for health care (instructions about who you want to make medical decisions for you if you are not able to make them)? Yes No Don't know

Would you like more information about a Living Will or a Power of Attorney? Yes No

SYMPTOMS – Review of Systems:

Please check all that apply to you

CONSTITUTIONAL:

- Fever
- Night sweats
- Weight gain lbs _____
- Weight loss lbs _____
- Exercise intolerance

EYES:

- Dry eyes
- Irritation
- Vision change

EARS, NOSE MOUTH, THROAT:

- Difficulty hearing
- Ear pain
- Frequent nosebleeds
- Nose/sinus problems
- Sore throat
- Bleeding gums
- Snoring
- Dry mouth
- Oral abnormalities
- Mouth ulcer
- Teeth abnormalities

CARDIOVASCULAR:

- Chest pain on exertion
- Arm pain on exertion
- Shortness of breath when walking
- Shortness of breath when lying down
- Palpitations
- Known heart murmur
- Light-headed on standing

RESPIRATORY:

- Cough
- Wheezing
- Shortness of breath
- Coughing up blood
- Sleep apnea

GATROINTESTINAL:

- Abdominal pain
- Heartburn
- Vomiting
- Change in appetite
- Black or tarry stools
- Diarrhea
- Constipation
- Vomiting blood

GENITOURINARY:

- Urinary loss
- Difficulty urinating
- Increased urinary frequency
- Blood in urine (hematuria)
- Incomplete emptying

URINARY FEMALE:

- Abnormal vaginal discharge
- Bleeding between periods
- Breast lump
- Hot flashes
- Irregular periods
- Painful intercourse
- Severe menstrual pain
- Sore(s) on genitals

URINARY MALE:

- Lump in testicle
- Penis discharge
- Sore(s) on genitals
- Inadequacy of penile erection

MUSCULOSKELETAL:

- Muscle aches
- Muscle weakness
- Joint pain
- Back pain
- Edema

SKIN:

- Abnormal mole
- Jaundice
- Rash
- Nail problem
- Itching
- Dry skin
- Growths/lesions

NEUROLOGIC:

- Loss of consciousness
- Weakness
- Numbness
- Memory/Loss
- Seizures
- Dizziness
- Headaches
- Migraine
- Restless legs

PSYCHIATRIC:

- Depression
- Anxiety
- Sleep disturbances/restless sleep
- Feel unsafe in a relationship
- Alcohol overuse

ENDOCRINE:

- Fatigue
- Increased thirst
- Hair loss
- Increased hair growth
- Cold intolerance

HEMATOLOGIC/LYMPHATIC:

- Swollen glands
- Easy bruising
- Excessive bleeding

ALLERGIC/IMMUNOLOGIC:

- Runny nose
- Sinus pressure
- Itching
- Hives
- Frequent sneezing

Reviewed by:

PHYSICIAN

DATE