PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

1. **PROBLEMS** that bring you to see the doctor: _____
   _____
   _____

2. **PREVIOUS MEDICAL HISTORY**: (List all diseases/diagnoses)
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

3. **ALLERGIES**: (to drugs, antibiotics, pollens and/or chemicals) Describe reaction to each.
   Substance & Reaction: _____ Substance & Reaction: _____
   Substance & Reaction: _____ Substance & Reaction: _____
   Substance & Reaction: _____ Substance & Reaction: _____

4. **MEDICATIONS**: (List all medications & supplements that you are currently taking).
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

5. **SURGERIES**: Inpatient & Outpatient (List the surgery/procedure, month and year (if known), and physicians name (if known).

Surgery	*Month/Year*	*Physician*
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. **HOSPITALIZATIONS**: (List the cause/diagnosis, month and year (if known), and physicians name (if known).

Cause	*Month/Year*	*Physician*
_____	_____	_____
_____	_____	_____

7. **INJURIES**: (List the injury, month and year (if known), and physicians name (if known).

Injury	*Month/Year*	*Physician*
_____	_____	_____
_____	_____	_____

8. **CHILDHOOD DISEASES AND VACCINATIONS**: (copy of vaccination record OK)
   _____ _____ _____
   _____ _____ _____

9. **LIST FOODS THAT YOU REACTED TO AS A CHILD OR NOW**:
   _____ _____ _____
   _____ _____ _____

10. **OB-GYN HISTORY**:
    a. Age at onset of menstruation: _____
    b. Age that menstruation stopped: _____
    c. First day of last menstrual period: _____
    d. Date of last pap smear: _____
    e. Number of pregnancies: _____
    f. Number of term deliveries: _____
    g. Number of preterm deliveries: _____
    h. Number of miscarriages: _____
    i. Number of abortions: _____
    j. Number of living children: _____
    k. Ages of children: _____
       _____

PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____

11. FAMILY HISTORY	FATHER	MOTHER	OTHER IMMEDIATE FAMILY	ELABORATION?
Heart Disease				
Heart Attack				
Diabetes				
Hyperthyroidism				
Hypothyroidism				
High Blood Pressure				
Stroke				
Epilepsy				
Cancer				
Tuberculosis				
Emphysema				
Asthma				
Allergies				
Liver Disease				
Alcoholism				
Stomach Ulcer				
Duodenal Ulcer				
Kidney Disease				
Glaucoma				
Sickle Cell Anemia				
Other Anemia				
Mental Illness				
Suicide				
Birth Defects				
Genetic Disease				
Other Serious Disease				

12. SOCIAL HISTORY:

a. Occupation

i. Past occupations: _____ _____

_____ _____

b. Married: ____ Single: ____ Divorced: ____ Separated: ____ Widowed: ____ (please check one)

i. Number of times married: _____

c. Smoking history: N/A_____ Average number of packs per day: _____ Number of years used: _____

d. Alcohol history: (type, frequency of use, number of years used)

i. Beer How often? ___/week ___/month ___/year How many years used? _____

ii. Wine How often? ___/week ___/month ___/year How many years used? _____

iii. Liquor How often? ___/week ___/month ___/year How many years used? _____

e. Illicit or intravenous drug use (type, frequency of use, number of years) N/A_____

i. Substance: _____ How many years? ____ How often? ___/week___/month___/year

f. Other pertinent social history: (names of children; significant changes in job, relationships, pets, home, health, etc., that have caused stress or relieved stress.

PATIENT MEDICAL HISTORY FORM

PATIENT: _____

**********REVIEW OF SYMPTOMS**********

1. HEAD AND NECK
   - ____Frequent or persistent headaches
   - ____Neck pains
   - ____Neck lumps or swelling
2. EYES
   - ____Wear glasses
   - ____Blurry vision
   - ____Double vision/seeing double
   - ____Seeing halos
   - ____Eye pain or itching
   - ____Watering eyes
   - ____Eye trouble
3. EARS
   - ____Hearing difficulties
   - ____Earaches
   - ____Drainage from ears
   - ____Ringing or buzzing in ears
   - ____Motion sickness
4. MOUTH
   - ____Dental problems
   - ____Swelling on gums/jaws
   - ____Sore tongue
   - ____Taste changes
5. NOSE and THROAT
   - ____Congested nose
   - ____Running nose
   - ____Sneezing spells
   - ____Head colds
   - ____Nosebleeds
   - ____Sore throat
   - ____Enlarged tonsils
   - ____Persistent hoarseness
6. RESPIRATORY
   - ____Wheezes or gasps
   - ____Coughing spells
   - ____Coughing up phlegm
   - ____Coughing up blood
   - ____Chest colds/bronchitis
   - ____Excessive sweating
   - ____Rib pain with breathing
7. CARDIOVASCULAR
   - ____High blood pressure
   - ____Low blood pressure
   - ____Racing heart or irregular heartbeat
   - ____Chest pain
   - ____Shortness of breath
   - ____Dizzy spells
   - ____Leg cramps
   - ____Hot flashes
   - ____Heart murmur
   - ____History of rheumatic fever
8. DIGESTIVE
   - ____Poor appetite
   - ____Heartburn or indigestion
   - ____Bloated stomach
   - ____Belching
   - ____Abdominal pain
   - ____Nausea
   - ____Vomiting ____Vomiting blood
   - ____Difficulty swallowing
   - ____Constipation
   - ____Loose stools
   - ____Black or tar-like stools
   - ____Grey stools
   - ____Pain in rectum
   - ____Rectal bleeding
   - ____Gallbladder problems
   - ____Hemorrhoids
9. URINARY
   - ____Frequency
   - ____Frequency: Daytime___ Nighttime___
   - ____Wet pants or bed
   - ____Burning on urination
   - ____Brown, black or bloody urine
   - ____Difficulty starting urine
   - ____Urgency
10. MALE GENITAL
    - ____Weak urine stream
    - ____Prostate problem
    - ____Discharge or burning
    - ____Lumps on testicles
    - ____Painful testicles
11. FEMALE GENITAL/BREAST
    - ____Menstrual trouble
    - ____Breakthrough bleeding
    - ____Heavy bleeding
    - ____Premenstrual bleeding/spotting
    - ____Birth control pill
    - ____Lumps in breasts
    - ____Vaginal discharge
    - ____Pap smear: Normal____ Abnormal____
    - ____Breast lump(s)
    - ____Discharge from nipple(s)
    - ____Other breast problem

PATIENT MEDICAL HISTORY FORM

PATIENT: _____

********** REVIEW OF SYMPTOMS CONT'D. **********

12. MUSCULOSKELETAL
    - ____Aching joints or muscles
    - ____Swollen joints
    - ____Back or shoulder pain
    - ____Painful feet
    - ____Handicapped
    - ____Lump/swelling in muscle or on bone
13. SKIN
    - ____Skin problems
    - ____Itching or burning skin
    - ____Bleed easily
    - ____Bruise easily
    - ____Acne
14. NEUROLOGICAL
    - ____Fainting spells
    - ____Dizziness
    - ____Numbness
    - ____Convulsions
    - ____Change in handwriting
    - ____Trembling
    - ____Difficulty with balance
    - ____Weakness in arms, legs, back or neck
    - ____Speech difficulty
15. ENDOCRINE
    - ____Hungry all the time
    - ____Thirsty all the time
    - ____Intolerant to cold
    - ____Intolerant to heat
    - ____Thyroid trouble
    - ____Unusually tired or sluggish
    - ____Unusually jumpy or nervous
16. PSYCHOLOGICAL
    - ____Nervous with strangers
    - ____Difficulty making decisions
    - ____Lack of concentration
    - ____Lonely or depressed
    - ____Cries often
    - ____Hopeless outlook
    - ____Difficulty relaxing
    - ____Worries a lot
    - ____Frightening dreams or thoughts
    - ____Shy or sensitive
    - ____Dislikes
    - ____Loses temper easily
    - ____Annoyed by little things
    - ____Work or family problems
    - ____Sexual difficulties
    - ____Considered suicide
    - ____Attempted suicide
    - ____Desired psychiatric help
17. GENERAL
    - ____Weight gain
    - ____Weight loss
    - ____Loss of interest in eating
    - ____Armpits or groin swelling
    - ____Fatigue/tiredness
    - ____Generalized weakness
    - ____Bites nails
    - ____Difficulty falling asleep
    - ____Difficulty staying asleep
    - ____Can't go back to sleep after awakening
    - ____Lack of exercise (<20 mins aerobic/day)
    - ____Watches a lot of TV (>1 hour/day)
    - ____A lot of time on computer (>1 hour/day)
    - ____Feels better when on vacation (out of town)
    - ____Feels worse when on vacation (out of town)
    - ____Feels same when on vacation (out of town)
    - ____Feels better when returning home from vacation or out of town
    - ____Feels worse when returning home from vacation or out of town
    - ____Feels same when returning home from vacation or out town