

Medical History Form

The information you provide to your doctor is confidential and can not be released without your authorization.

NAME _____

MYCIS No. _____ DATE _____

Medical Problems

- | | | | | |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bone disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Gout | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> TIAs (mini strokes) | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High / low potassium | <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Diabetes type <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Mental illness |
| Year of last normal BP: _____ | Year of onset: _____ | Complications: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Nerve | | <input type="checkbox"/> Other Disorder |
| | | | | # Pregnancies _____ |
| | | | | # Deliveries _____ |

For physician use.
Mental illness

Hospitalizations

Please list all of your previous visits to the hospital, include ER visits and surgeries.

Reason for hospitalization	Date	For physician use

For physician use.

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NAME _____

MYCIS No. _____ DATE _____

Family Medical History

Relative	Age	Living	Diseases (kidney disease, hypertension, diabetes, heart disease, cancer, others)
Father		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sibling: <input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sibling: <input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sibling: <input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Social History

Type	Current	Past	How much?	How long?
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>		
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>		

For physician use.
Sexuality

What exercise do you do: _____ Describe your job: _____

Medication History

Current Medications	Dose (mg)	Times a day	Ordering Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

List any adverse or allergic reactions you have had to any previous medications. Specifically include any medication that caused a high potassium, a cough or your face swell.

Fellow/APN _____

Attending _____

Date: _____

St. Clair Specialty Physicians, P.C.

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? Circle **Yes** or **No**.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Significant Weight Loss/Gain	Y	N

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
Palpitations	Y	N
Other _____		

Physician use only: (Comments/Notes)

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Fellow/APN _____

Attending _____

Date: _____

St. Clair Specialty Physicians, P.C.