Medical History Form

The information you provide to your doctor is confidential and cannot be released without your permission.

Name:______________________________________ DOB:__________ Today's Date:_____________

Reason for visit:____

____

____

1. ALLERGIES

Please specifically include any medications that caused high potassium, a cough or face to swell.

____

____

____

2. IMMUNIZATIONS

- ☐ Flu Vaccine — Date of Immunization: __________________ Place received:__________________________
- ☐ Pneumonia — Date of Immunization: __________________ Place received:__________________________
- ☐ Hepatitis B — Date of Immunization: __________________ Place received:__________________________

3. FAMILY MEDICAL HISTORY

Relative	Age	Living	Medical Conditions
Father		☐ yes ☐ no	
Mother		☐ yes ☐ no	
Sibling: ☐ M ☐ F		☐ yes ☐ no	
Sibling: ☐ M ☐ F		☐ yes ☐ no	
Sibling: ☐ M ☐ F		☐ yes ☐ no	
Other:		☐ yes ☐ no	
Other:		☐ yes ☐ no	

4. SOCIAL HISTORY

Type	Yes	No	How much?	How long?
Tobacco	☐	☐		
Alcohol	☐	☐		
Illicit Drug Use	☐	☐		

Exercise (what exercise do you do and how often?):____

Occupation (describe your job):____

5. MEDICATION & VITAMINS

List Current Medications or Vitamins	Dose (mg)	Times a day	Ordering Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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Name:____ DOB: ______________

6. PREGNANCY

Number of Pregnancies:______________ Number of Deliveries:____________________

7. SURGERIES

Surgery	Year	Location

8. MEDICAL PROBLEMS

- ☐ Stroke
- ☐ TIAs (mini strokes)
- ☐ Dementia
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Bone Disease
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Emphysema
- ☐ Cancer
- ☐ Sleep Apnea
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Kidney Disease
- ☐ High/Low Potassium
- ☐ Liver Disease
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
  - Year of onset:__________
  - Complications: ☐ Eye ☐ Kidney ☐ Nerve
- ☐ Gout
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bowel Disease
- ☐ Stomach Ulcers
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Transfusion
- ☐ Anemia
- ☐ Blood Clots
- ☐ Mental Illness
- ☐ Other Disorder

9. HEALTH MAINTENANCE

	Yes	No	N/A	
Colonoscopy Screening (50-75 years of age)	☐	☐	☐	Date of last screening:______________
Mammogram Screening (41-69 years of age)	☐	☐	☐	Date of last screening:______________
Pap Smear (23-64 years of age)	☐	☐	☐	Date of last screening:______________

Physician use only.

Name:____ DOB:________________________________

Review of Systems

For each symptom below, please circle the appropriate answer.

Constitutional Symptoms

Chills Yes / Not Currently
Fever Yes / Not Currently
Significant Weight Loss Yes / Not Currently
Significant Weight Gain Yes / Not Currently
Headache Yes / Not Currently

Integumentary

Persistent Itch Yes / Not Currently
Skin Rash Yes / Not Currently
Other____

Eyes/Ear/Nose/Throat

Eye Pain Yes / Not Currently
Visual Changes Yes / Not Currently
Difficulty Hearing Yes / Not Currently
Ear Pain Yes / Not Currently
Hay Fever Yes / Not Currently
Sinus Pain Yes / Not Currently
Throat Pain Yes / Not Currently
Other____

Respiratory

Frequent cough Yes / Not Currently
Snoring Yes / Not Currently
Shortness of breath Yes / Not Currently
Wheezing Yes / Not Currently
Other____

Cardiovascular

Chest pain Yes / Not Currently
Heart skips a beat Yes / Not Currently
Swelling Yes / Not Currently
Varicose Veins Yes / Not Currently
Palpitations Yes / Not Currently
Other____

Gastrointestinal

Abdominal Pain Yes / Not Currently
Diarrhea/ Constipation Yes / Not Currently
Nausea Yes / Not Currently
Vomiting Yes / Not Currently
Other____

Genitourinary

Difficulty Urinating Yes / Not Currently
Urinary frequency Yes / Not Currently
Painful Urination Yes / Not Currently
Urine Retention Yes / Not Currently
Other____

Musculoskeletal

Joint pain Yes / Not Currently
Back pain Yes / Not Currently
Muscle pain Yes / Not Currently
Neck Pain Yes / Not Currently
Other____

Neurological

Dizzy spells Yes / Not Currently
Numbness Yes / Not Currently
Tingling Yes / Not Currently
Tremors Yes / Not Currently
Other____

Psychological

Do you feel severely depressed? yes / no
Tired/Sluggish, if so, pick a reason below:
☐ Trouble Sleeping
Other____

Endocrine

Too hot/ too cold Yes / Not Currently
Excessive thirst Yes / Not Currently

Hematologic/Lymphatic

Bruising/Bleeding Yes / Not Currently
Other____

Physician Comments: