MEDICAL HISTORY

NAME:______________________________ DOB:___________ TODAY'S DATE:____________

CURRENT MEDICAL PROBLEMS:

1.________________________________ 4.________________________________
2.________________________________ 5.________________________________
3.________________________________ 6.________________________________

PAST MEDICAL HOSPITALIZATIONS:

	Reason	Yr		Reason	Yr
1.			5.		
2.			6.		
3.			7.		
4.			8.		

SURGERIES:

	Procedure	Yr		Procedure	Yr
1.			5.		
2.			6.		
3.			7.		
4.			8.		

MEDICATIONS(Include strength and how taken)

1.________________________________ 6.________________________________
2.________________________________ 7.________________________________
3.________________________________ 8.________________________________
4.________________________________ 9.________________________________
5.________________________________ 10.________________________________

MEDICATION ALLERGIES:

____
____

FAMILY HISTORY

Diabetes (adult onset)	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Diabetes(juvenile onset)	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
High blood pressure	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Heart disease	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Stroke	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Breast cancer	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Colon cancer	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Prostate cancer	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Alzheimers	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling
Other______________	O Fath	O Moth	O Broth	O Sis	O GrandPar	O Aunt	O Uncle	O >1Sibling

Father: O Healthy O Poor health O Deceased Age:____ O Sisters: #Born_____ #Living______
Mother: O Healthy O Poor health O Deceased Age:____ O Brothers: #Born_____ #Living______

SYMPTOM INVENTORY

Name________________________________

Are you currently having?

GENERAL

- O Yes | O No Unusual persistent fatigue
- O Yes | O No General malaise
- O Yes | O No Unintended weight gain
- O Yes | O No Unintended weight loss
- O Yes | O No Night sweats

EYES/EARS

- O Yes | O No Sudden visual change
- O Yes | O No Eye pain
- O Yes | O No Eye discharge/drainage
- O Yes | O No Wear glasses to read only
- O Yes | O No Wear glasses (at all times)
- O Yes | O No Double vision
- O Yes | O No Sudden change of hearing
- O Yes | O No Ear pain
- O Yes | O No Ear drainage/discharge
- O Yes | O No Frequent ear infections
- O Yes | O No Ringing in the ear(s)
- O Yes | O No Use hearing aids

NASAL-SINUS

- O Yes | O No Persistent nasal congestion
- O Yes | O No Persistent nasal discharge
- O Yes | O No Allergic rhinitis (hayfever)
- O Yes | O No Chronic sinus infections

ORAL-PHARYNX

- O Yes | O No Mouth sores
- O Yes | O No Gum pain
- O Yes | O No Toothache
- O Yes | O No Wear dentures
- O Yes | O No Dry mouth
- O Yes | O No Sore throat
- O Yes | O No Post-nasal drainage
- O Yes | O No Hoarseness
- O Yes | O No Difficulty swallowing
- O Yes | O No Bad breath

RESPIRATORY

- O Yes | O No Chronic cough
- O Yes | O No Daily productive cough
- O Yes | O No Short of breath with activity
- O Yes | O No Short of breath at rest
- O Yes | O No Coughing up blood
- O Yes | O No Wheezing
- O Yes | O No Asthma
- O Yes | O No Recurrent bronchitis
- O Yes | O No Recurrent pneumonia

CARDIOVASCULAR

- O Yes | O No Chest pain with exertion
- O Yes | O No Shortness of breath lying down
- O Yes | O No Episodes of shortness of breath at night
- O Yes | O No Palpitations
- O Yes | O No History of heart murmur
- O Yes | O No History of rheumatic fever
- O Yes | O No Calf/thigh pain with walking
- O Yes | O No History of previous heart attack
- O Yes | O No History of high blood pressure

GASTROINTESTINAL

- O Yes | O No Frequent/chronic indigestion
- O Yes | O No Acidic reflux/backwash
- O Yes | O No Difficulty swallowing
- O Yes | O No Persistent abdominal pain
- O Yes | O No History of ulcers
- O Yes | O No Frequent vomiting
- O Yes | O No Persistent diarrhea
- O Yes | O No Persistent constipation
- O Yes | O No Recent change in bowel habits
- O Yes | O No Rectal bleeding/blood in stool
- O Yes | O No Black stool
- O Yes | O No Hemorrhoids
- O Yes | O No Rectal pain
- O Yes | O No History of hepatitis

DERMATOLOGIC

- O Yes | O No Persistent rash
- O Yes | O No Psoriasis
- O Yes | O No Itching
- O Yes | O No Changing mole
- O Yes | O No Previous skin cancer

URINARY

- O Yes | O No Pain with urination
- O Yes | O No Urinary frequency
- O Yes | O No Up >1 time at night to urinate
- O Yes | O No Blood in urine
- O Yes | O No History of kidney stones

MALE ONLY

- O Yes | O No Discharge from penis
- O Yes | O No History of recurrent prostate infection
- O Yes | O No History of prostate enlargement
- O Yes | O No Inadequate erections

FEMALE ONLY
O Yes | O No Unexpected vaginal bleeding
O Yes | O No Gone through menopause
O Yes | O No Irregular menstrual periods
O Yes | O No Excessively painful periods
O Yes | O No Previous hysterectomy
O Yes | O No Persistent pelvic pain
O Yes | O No Breast lump
O Yes | O No Breast discharge
O Yes | O No Breast pain

ENDOCRINE
O Yes | O No Unusual hair loss
O Yes | O No Excessive thirst
O Yes | O No Unusually hot or cold
O Yes | O No Flushing
O Yes | O No History of goiter

NEUROLOGIC
O Yes | O No Migraine headaches
O Yes | O No Tension or other frequent headaches
O Yes | O No Recurrent fainting
O Yes | O No History of seizure
O Yes | O No Foot or leg numbness
O Yes | O No Numbness of hand or arm
O Yes | O No Dizziness
O Yes | O No Trouble with balance
O Yes | O No Tremor
O Yes | O No Previous stroke

ALLERGIC/IMMUNE
O Yes | O No Allergy problems
O Yes | O No Recurrent hives
O Yes | O No Hay fever
O Yes | O No Taking prednisone
O Yes | O No Recurrent infections

HEMATOLOGIC/LYMPH
O Yes | O No Easy bruising
O Yes | O No Bleeding gums
O Yes | O No Enlarged lymph nodes
O Yes | O No Immune deficiency
O Yes | O No History of anemia
O Yes | O No Blood disorder

MUSCULOSKELETAL
O Yes | O No Joint pain
O Yes | O No Swollen joints
O Yes | O No Persistent back pain
O Yes | O No Persistent muscle pain
O Yes | O No Persistent neck pain
O Yes | O No History of osteoporosis
O Yes | O No Muscle weakness

PSYCHIATRIC
O Yes | O No History of anxiety
O Yes | O No History of depression
O Yes | O No Trouble sleeping
O Yes | O No Frequent crying
O Yes | O No Panic attacks
O Yes | O No Loss of interest in sex
O Yes | O No History of alcohol abuse
O Yes | O No History of drug abuse

Maritial Status: O Married O Single O Divorced O Widowed
Employment: O Full time O Part time O Unemployed O Full Time Student O Homemaker O Retired
Occupation:___________________________
Do you smoke cigarettes? O Yes O No How many packs per day?______
Do you smoke cigars or a pipe? O Yes O No How many per day?______
Do you chew tobacco or dip ? O Yes O No How many times per day?_____
Do you drink alcoholic beverages? O Never O Rarely O Occaionally O Frequently #Drinks/wk_____
Do you smoke marijuana? O Never O Rarely O Occaionally O Frequently #Joints/wk_______
Do you use cocaine or other drugs? O Never O Rarely O Occaionally O Frequently
Do currently use intravenous drugs? O Never O Rarely O Occaionally O Frequently
Have you ever used intravenous drugs O Yes O No
Do your wear seatbelts when driving? O Yes O No
Do you exercise regularly? O Yes O No