SimplyCare

Patient Medical History Form

Patient Name: DOB: Visit Date:

General

Weight Loss:	O Yes	O No
Decreased appetite:	O Yes	O No
Fatigue:	O Yes	O No
Fever:	O Yes	O No
Night Sweats:	O Yes	O No

Gastrointestinal

Nausea:	O Yes	O No
Vomiting:	O Yes	O No
Abdominal pain:	O Yes	O No
Vomiting Blood:	O Yes	O No
Gas:	O Yes	O No
Bloating:	O Yes	O No
Heartburn:	O Yes	O No
Trouble swallowing:	O Yes	O No
Stomach Ulcers:	O Yes	O No
Change in bowel habits:	O Yes	O No
Constipation:	O Yes	O No
Diarrhea:	O Yes	O No

Endocrine

Thyroid Problems:	O Yes	O No
Low Blood Sugar:	O Yes	O No

Eyes

Glaucoma:	O Yes	O No
Cataracts:	O Yes	O No

Ear, Nose and Throat

Dentures:	O Yes	O No
Hoarseness:	O Yes	O No
Sinusitis:	O Yes	O No
Post Nasal drainage:	O Yes	O No

Cardiovascular

Chest pain:	O Yes	O No
Palpitations:	O Yes	O No
Murmur:	O Yes	O No
Heart Attack:	O Yes	O No
Abnormal Heart rhythm:	O Yes	O No

Respiratory

Home oxygen:	O Yes	O No
Shortness of Breath:	O Yes	O No
Chronic cough:	O Yes	O No
TB (tuberculosis):	O Yes	O No

Skin

Yellowing (jaundice):	O Yes	O No
Rashes:	O Yes	O No
Bruising:	O Yes	O No

Musculoskeletal

Arthritis:	O Yes	O No
Ongoing Back pain:	O Yes	O No
Leg Cramps:	O Yes	O No

Hematologic

Plavix usage: O Yes O No

Coumadin usage: O Yes O No

Aspirin usage: O Yes O No

Other blood thinner: O Yes O No

Naproxy,Advil,Motrin: O Yes O No

(Non-steroidal anti-inflammatory usage)

Anemia: O Yes O No

Clotting problems: O Yes O No

Prior transfusions: O Yes O No

Neurologic

Alzheimer's: O Yes O No

Neuromuscular Disease: O Yes O No

Seizure: O Yes O No

Sleep disturbances: O Yes O No

Neurologic Cont'd

Confusion: O Yes O No

Headache: O Yes O No

Reproductive/Urinary

Kidney Stones: O Yes O No

Burning w/ Urination: O Yes O No

Blood in urine: O Yes O No

Are you Pregnant?: O Yes O No

Psychiatric

History of Mental illness: O Yes O No

Anxiety: O Yes O No

Depression: O Yes O No

Stress: O Yes O No

Memory loss or confusion: O Yes O No

Family History **Mark only those that apply or NONE**

Mother O Living O Deceased

O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Father O Living O Deceased

O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Grandparents O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Siblings O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Children O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Past Medical History (Mark only those that apply or NONE)

NONE O

GERD/Heartburn:	O Yes	Pacemaker:	O Yes
Ulcers:	O Yes	AICD(Defibrillator):	O Yes
Colon Polyps:	O Yes	COPD:	O Yes
Irritable Bowel Syndrome:	O Yes	Diabetes:	O Yes
Diverticulosis:	O Yes	Elevated Cholesterol:	O Yes
Pancreatitis:	O Yes	Stroke:	O Yes
Crohn's Disease:	O Yes	Fibromyalgia:	O Yes
Ulcerative Colitis:	O Yes	Arthritis:	O Yes
Hypertension:	O Yes	Chronic Back pain:	O Yes
Coronary Artery Disease:	O Yes	Cancer:	O Yes
Cardiac Stent:	O Yes	Renal Failure:	O Yes
Congestive Heart Failure:	O Yes	Dialysis:	O Yes
Atrial Fibrillation:	O Yes	Sleep Apnea:	O Yes
Valvular Heart Disease:	O Yes		

Social History

Marital status: O Married O Single O Divorced O Widowed O Life Partner

Occupation: O Full Time O Part Time O Retired O Homemaker

O Student O Unemployed O Disabled

Smoke : O Yes O No O Trying to Quit O Previous smoker

Smokeless Tobacco: O Yes O No O Trying to Quit O Previously

Alcohol: O Never O Daily O Social Drinker O Trying to Quit O Recovering Alcoholic

Illegal Drugs: O Yes O No O Recovering Addict

Tattoos: O Yes O No

HIV infected: O Yes O No O Unknown (never been tested)

Who Lives with you: O Spouse O Children O Partner O Mother O Father O No one

Surgical History **NONE** O (Please mark NONE if nothing below applies)

Colonoscopy:	O Yes Year: ______	Breast Cancer Surgery:	O Yes Year:_______
EGD(Upper endoscopy):	O Yes Year:_______	Prostate Surgery:	O Yes Year:_______
Ulcer Surgery:	O Yes Year:_______	Back Surgery:	O Yes Year:_______
Colon Surgery:	O Yes Year:_______	Hip Surgery:	O Yes Year:_______
Cholecystectomy:	O Yes Year:_______	Knee Surgery:	O Yes Year:_______
Appendectomy:	O Yes Year:_______	Other Knee Surgery:	O Yes Year:_______
Hemorrhoidectomy:	O Yes Year:_______	Weight Loss Surgery:	O Yes Year:_______
Bypass Surgery:	O Yes Year:_______	_________________:	O Yes Year:_______
Heart Valve Replacement:	O Yes Year:_______	_________________:	O Yes Year:_______
Hysterectomy:	O Yes Year:_______	_________________:	O Yes Year:_______
Ovaries Removed:	O Yes Year:_______		

Prescription Medications:____

____

Over the Counter Medications: ____

____

Diet Pills & Herbal Medications:_____Yes_____NO Examples include, but not limited to, diet pills,

St. John's Wort, Epedra, Garlic, Ginko : ____

Allergies to Medications: _____Yes _____ NO Please list:____

Latex Allergies: _____ Yes____ NO

List all current Doctors: ____

____