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PATIENT MEDICAL HISTORY

Patient Name ________________________________ Date of Birth_________________________

Reason for today's visit ____

PREVENTIVE HISTORY

Check all that apply and provide date of diagnosis or test:

			Year of Diagnosis
High Blood Pressure	☐ yes	☐ no	______
High Cholesterol	☐ yes	☐ no	______
Diabetes	☐ yes	☐ no	______

			Year of Test:	Where was it prerformed:		
Colonoscopy	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Bone Density Test	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Heart Stress Test	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Heart Catheterization	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Urinary Incontenance	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Male Patients						
PSA Test	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Female Patients						
Mammogram	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal
Pap Smear	☐ yes	☐ no	______	______	☐ Normal	☐ Abnormal

Number of Pregnancies: ________ Number of Births: ______ Date of Last Menstral Period _______________

CURRENT MEDICATIONS

What medicatons are you currently taking?

Name	Dosage	Frequency

ALLERGIES

Please list any known allergies

____

____

____

____

HOSPITALIZATIONS, PROCEDURES OR SURGERIES

Please list any surgeries, procedures or recent hospitalizatons (continue on back, if necessary):

Reason	Hospital	Date
Reason	Hospital	Date
Reason	Hospital	Date

FAMILY HISTORY

Anyone in your immediate family had the following: Details-Please list family members:

☐ Alcoholism	☐ High Cholesterol
☐ AIDS/HIV	☐ High Blood Pressure
☐ Blood Clots	☐ Kidney Disease
☐ Breast Cancer	☐ Liver Disease
☐ Colon Cancer	☐ Lung Disease
☐ Colon Polyps	☐ Prostate Cancer
☐ Diabetes	☐ Stroke
☐ Heart Attack	☐ Substance Abuse
☐ Osteoperosis	☐ Blood Disorder
☐ Hepatitis	☐ Cancer

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IMMUNIZATIONS

List the date and location where you received the following vaccines:

				Office/Pharmacy:	City/Street:
Influenza	Y	N	Date ________		
Tetanus	Y	N	Date ________		
Pneumococcal	Y	N	Date ________		
Prevnar 13	Y	N	Date ________		
DTAP/Whooping Cough	Y	N	Date ________		
Zoster/Shingles	Y	N	Date ________		
Varicella	Y	N	Date ________		
Other	________		Date ________		

SOCIAL HISTORY/LIFESTYLE

Please tell us a little about your lifestyle:

Occupation: ______________________________

Exercise: Type? ______________ How long? ________ How often? ________ times per week

	Current Use		Past Use		How often per week	How much per day
Smoking	Y	N	Y	N		
Caffeine	Y	N	Y	N		
Alcohol	Y	N	Y	N		
Drug Use	Y	N	Y	N		

SELF EVALUATION

Give us some information about your ability to care for yourself

How would you rate your health in general? ____excellent ____good ____fair ____poor

Are you confident in handling your health and health problems? _______yes _______no

REVIEW OF SYSTEMS

Please circle any that you have experienced in the last 3 months

CONSITUTIONAL			GASTROINTESTINAL		
Y	N	Changes in appetite	Y	N	Black, tarry stool
Y	N	Night sweats	Y	N	Bloody stool
Y	N	Fever	Y	N	Constipation
Y	N	Chills	Y	N	Heartburn
Y	N	Fatigue	Y	N	Indigestion
Y	N	Recent weight gain (____lbs)	Y	N	Vomitting/Nausea
Y	N	Recent weight loss (____lbs)	Y	N	Abdominal pain or cramping
URINARY			**CARDIOVASCULAR**		
Y	N	Blood in urine	Y	N	Fainting
Y	N	Painful urination	Y	N	Fast heart rate
Y	N	Urinating at night	Y	N	Irregular heart beat
Y	N	Involuntary loss of urine	Y	N	Chest pain
Y	N	Painful intercourse	Y	N	Swelling of extremities
Y	N	Menstral irregularities	Y	N	Difficulty breathing while laying down
ENDOCRINE			**PSYCHIATRIC**		
Y	N	Increased thirst	Y	N	Anxiety
Y	N	Heat/Cold intolerance	Y	N	Suicidal thoughts
Y	N	Excessive urination	Y	N	Substance abuse
Y	N	Skin, hair or fingernail changes	Y	N	Little interest/pleasure in doing things
NEUROLOGICAL			**SKIN**		
Y	N	Numbness	Y	N	Change in moles or warts
Y	N	Headaches	Y	N	Rash
Y	N	Dizziness	Y	N	Sores that will not heal
Y	N	Loss of Balance	Y	N	Yellowing of the skin
EYES			**RESPIRATORY**		
Y	N	Recent change in vision	Y	N	Wheezing
Y	N	Double vision	Y	N	Cough
Y	N	Eye pain	Y	N	Shortness of breath with normal activity
MUSCULOSKELETAL			**HEME/LYMPH**		
Y	N	Joint pain	Y	N	Easy bruising
Y	N	Muscle pain	Y	N	Enlarged lymph nodes
Y	N	Prolonged morning joint pain	Y	N	New breast lumps
EAR, NOSE, AND THROAT			**EAR, NOSE, AND THROAT**		
Y	N	Loss of hearing	Y	N	Hoarseness
Y	N	Nasal congestion	Y	N	Ringing in the ears
Y	N	Snoring	Y	N	Seasonal allergies
Y	N	Trouble swallowing	Y	N	Cold symptoms

Are there any other symptoms you need to discuss?

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Signature of Patient or Agent/Guardian | Date