



MEDICAL HISTORY FORM

Name _____ DOB ____/____/____ Date ____/____/____

CHIEF COMPLAINT/REASON FOR VISIT

PAST MEDICAL HISTORY (Circle all that apply)

Eyes/Ears/Nose: Glaucoma – Macular Degeneration – Cataracts – Hearing Loss – Nasal Allergies

Cardiac: High Blood Pressure – Heart Disease –Stroke – Atrial Fib – MVP

Respiratory: Asthma – Tuberculosis/Positive TB test -- Emphysema/COPD – Pneumonia

GI tract: Gallstones – Hepatitis – Ulcers – Acid Reflux Disease – GI Bleeding – Diverticulitis

Urinary: – Frequent Urinary Infections – Kidney Stones – Kidney Disease

Reproductive: – Irregular Periods

Endocrine: – Diabetes – High Cholesterol/Triglycerides – Gland Disorder (thyroid/parathyroid, pituitary, adrenal)

Joints: – Osteoporosis – Arthritis –Rheumatoid Arthritis – Lupus – Gout – Joint replacement

Blood/Oncology: – Anemia - Bleeding Disorder – DVT or clots – Cancer (type _____)

Nervous: – Headaches – Psychiatric Illness

Other: _____

MEDICATIONS

(list dosages, attach sheet if needed)

DRUG/LATEX/FOOD ALLERGIES

_____	_____
_____	_____
_____	_____

PAST SURGICAL HISTORY (list type and dates)

FAMILY MEDICAL HISTORY (Family Member Alive or Dead, Age Diseases)

OB/GYN HISTORY

Number of pregnancies _____ number of children _____ last menstrual period _____

SOCIAL HISTORY (Circle Yes or No and fill in appropriate blank)

Smoking: Yes No Packs/Day _____ Years _____

Exercise (Type/Frequency) _____

Caffeine on a regular basis: Yes No Cups/Day _____

Alcohol Intake: Yes No Daily Weekly

REVIEW OF SYSTEMS (circle all that apply)

General: fevers sweats weight change energy level exercise tolerance headaches

Skin: rashes lumps sores itching hair-nail changes changing moles

Eyes: vision problems glasses/contacts pain double vision glaucoma

Ears/Nose: hearing loss or ringing vertigo discharge stuffiness bleeding itching

Mouth/Throat: dentures dental pain sore throat bleeding gums tongue pain voice change

Neck: pain/stiffness lumps swollen glands thyroid problems

Breasts: pain lumps nipple discharge skin changes self-examination

Respiratory: cough sob sputum (describe) wheezing pleuritic chest pain apnea

Cardiovascular: chest pain/angina hypertension heart murmurs SOB while walking or sleeping palpitations claudication leg cramps history of DVT peripheral edema

Gastrointestinal: loss of appetite heartburn abdominal pain nausea or vomiting change in bowel habits constipation diarrhea hemorrhoids rectal bleeding/blood in stool

Genitourinary: frequent urination burning or painful urination blood in urine kidney stones periods irregular /heavy

Musculoskeletal: joint or back pain muscle aches stiffness swelling deformity

Neurologic: weakness numbness tingling dizziness/lightheadedness seizures gait problems speech difficulties memory problems

Hematologic: anemia bleeding problems easy bruisability prior transfusions enlarged glands

Endocrine: thyroid disease heat or cold intolerance excessive thirst or urination diabetes

Psychiatric: depression memory loss nervousness insomnia