Patient Medical History Sheet

Patient Name: ______________________________ Date of Birth:____________________ Date: ___________

Occupation: ______________________________ Allergies:_____________________________________________

MEDICAL HISTORY-Check (X) where appropriate

| YOU | RELATIVE | | YOU | RELATIVE | |
|---|---|---|---|---|---|
| _________ | ________ | Diabetes Mellitus | ______ | _____ | Reflux/Hiatal Hernia |
| _________ | _________ | Migraines/Headaches | ______ | _____ | Swallowing/Esophageal Problems |
| _________ | _________ | High Cholesterol/Triglycerides | ______ | _____ | Glaucoma/Vision Problems |
| _________ | __________ | High Blood Pressure | ______ | _____ | Seizures |
| _________ | _________ | Heart Disease/Attack | ______ | _____ | AIDS/HIV |
| _________ | _________ | Heart Failure/Valve | ______ | _____ | Liver Problems |
| __________ | _________ | Hearing Problems/Loss | ______ | _____ | Hepatitis/Cirrhosis |
| _________ | _________ | Cancer type | ______ | _____ | Stomach Ulcers/Gastritis |
| | | 1. _______________________ | ______ | _____ | Arthritis |
| | | 2. _______________________ | ______ | _____ | Rheumatoid/Lupus/Gout |
| __________ | __________ | Lung Disease | ______ | _____ | Osteoarthritis |
| _________ | _________ | Empysema/COPD | ______ | _____ | Thyroid Problems |
| _________ | _________ | Asthma | ______ | _____ | Skin Diseases |
| _________ | __________ | TB/PPD | ______ | _____ | Clotting/Bleeding disorders |
| _________ | _________ | Orthopedic Problems | ______ | _____ | Kidney Problems/Stones |
| _________ | _________ | Colitis | ______ | _____ | Depression/ Anxiety |
| _________ | _________ | Vascular disease(Aneurysm) | ______ | _____ | Anemia(Iron,B12) |
| _________ | __________ | Neuromuscular/MS | ______ | _____ | Other: ______________________ |

Please explain which relative below:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

SURGICAL HISTORY: Please list all surgeries and dates(if possible)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

MEDICATION AND DOSAGE: (Prescription, over the counter,vitamins, etc)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

SOCIAL HISTORY: Check (X) where appropriate

__ Tobacco __ How many packs/day? __ How many years?

______ Alcohol _____ How many drinks per week?

_______ Drugs ______________________________

_____ Coffee or tea ______ How many cups/day

___Have you ever had a blood transfusion?

______ Do you wear seatbelts?

_____Is there a gun in the home? _____Is it locked & ammo key separ

______ Do you have smoke detectors on every floor?

_______ Do you exercise regularly?

_____ Are you on a special diet?

_______ Engaged in risky sexual behavior?

_______ Have you ever come into contact with hazardous materials?

________ Are you in a relationship where you have been physically hurt?

______ Do you wear a bike helmet?

______ Do you have a living will?

______ Do you have a power of attorney?

_______ Are you an organ donor?

PREVENTATIVE CARE-- When was your last

_______ Chest X-ray  ________ Mammogram  __________ DEXA scan

_______ Pap Smear  Name of Gynecologist: ____________________________

_______ Prostate Exam  _______ Routine Blood work  ____________ Stool check for blood

_______ Colonoscopy  _________ Tetanus Shot  _____________ Pneumovax

________ Flu shot

REVIEW OF SYSTEMS (Recent Health Problems)

________ Hoarseness

________ Headaches

____ Hearing loss/ringing

______ Difficulty walking

________ Cough

_____ Rashes/Skin lesions

____ Depression/Anxiety

_______ Palpitations

_____ Change in appetite

_______ Other ______________

_______ Other ______________

____ Recurrent colds/sinus infections

_______ Vision problems

___ Sore throat/difficulty swallowing

_______ Weight loss

_______ Shortness of Breath

_______ Joint or muscle aches

_______ Any new lumps or masses

_______ Bleeding problems

_______ Memory problems

___ Nausea/vomiting

___ Ear pain/discharge

___ Dizziness/Lightheadness

____Sweats/Chills

____ Chest pain/pressure

____ Urinary difficulty/frequency

____ Swelling in legs/feet

_____ Abnormal bowel movements

_____ Problems with sexual intercourse

SPECIALISTS-- Please list names, specialty and phone number of all the specialists you see

Name:______________________________
Specialty:____________________________
Phone Number: ______________________

Name: ___________________________________
Specialty: _________________________________
Phone Number: ____________________________

Name: ______________________________
Specialty: ____________________________
Phone Number: ______________________

Name: ____________________________________
Specialty: _________________________________
Phone Number: ___________________________

Name:____________________________________
Specialty: __________________________________
Phone Number: ____________________________

Name: ____________________________________
Specialty:__________________________________
Phone Number:____________________________