

# MEDICAL HISTORY

**PLEASE COMPLETE WITH BLACK INK ONLY**

Date: \_\_\_\_\_

**Confidential Record:** Information here will not be released unless you have authorized us to do so.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

FAMILY HISTORY:	If Living		If Deceased	
	Age	Health	Age of Death	Cause of Death
Father				
Mother				
Brother/Sister (Circle Sex)				
M F				
M F				
M F				
M F				
M F				
Husband/Wife				
Sons/Daughter (Circle Sex)				
M F				
M F				
M F				
M F				
M F				

## FAMILY HISTORY:

Check if any blood relative has had any of the following and enter relationship:

	Yes	No	Relative:		Yes	No	Relative:		Yes	No	Relative:
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____	Congenital Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____
			_____	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____

## PAST HISTORY (PERSONAL)

Have you had any of the following illnesses?

	Yes	No		Yes	No	Operations: List and indicate approximate year
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Lung Infection	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ever had any transfusions? \_\_\_\_\_ Date \_\_\_\_\_

Hospitalizations (other than operations):  
List reasons and approximate dates.

**PAST HISTORY (continued)**

**MEDICATIONS:**

Please list all medicines, prescription or non-prescriptions:

**\*\*Include DOSAGE & DIRECTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication? Yes  No   
If yes, please list medications and the reaction to them.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Serious Injuries (this includes fractures) other than listed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you being treated by any other health care professionals? Yes  No   
If yes, please list their names:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PERSONAL HABITS**

- I use tobacco. Yes  No  Never   
 Smoke: \_\_\_\_\_ Number of cigarettes per day  
 Chew  
Age started \_\_\_\_\_ Age stopped \_\_\_\_\_
- Do you drink alcohol?  
 Daily  Weekly  Monthly  Never  
Type of alcohol \_\_\_\_\_
- Do you use recreational drugs? Yes  No  Never
- Do you use caffeine products?  
 Coffee  Soda  Tea
- Do you use seatbelts?  
 Always  Occasionally  Never

**MARITAL/FAMILY**

- |                                                                                           | Yes                      | No                       |
|-------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Have you been married more than one time?                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Has there been a recent change in marital status?                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any problems with your married life?                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any sexual problems?                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your present home life causing unhappiness?                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have there been any deaths in your family or among close friends in the past year or two? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does anyone in your family have a serious illness or disability?                          | <input type="checkbox"/> | <input type="checkbox"/> |

**OCCUPATIONAL**

- |                                                                                              | Yes                      | No                       |
|----------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Are you presently employed?                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your work involve unusual work, exposure to dust, noise, radioactivity, asbestos, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have more than one job?                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you work more than 60 hour weeks?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get along well with your fellow employees and/or supervisor?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you unable to perform any work because of disability?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you retired?                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| If retired, have you had difficulty adjusting to retirement?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**SOCIAL HISTORY**

- |                                                                                                               | Yes                      | No                       |
|---------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Have you recently lived or traveled outside the U.S.?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you complete high school education?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you attend and/or complete college?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you serve in any branch of the Military?<br>If so were you discharged?<br>Years served _____ Status _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been denied life or health insurance?                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you eat less than three meals a day?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have special food customs or restrictions?                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been treated for a drinking problem?                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you exercise three or more times a week?                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |

# Review of Systems:

## A. Health Maintenance

Immunization : Date of most recent	Test: Check if abnormal	Date
<input type="checkbox"/> Measles: _____	<input type="checkbox"/> Pap _____	
<input type="checkbox"/> Smallpox _____	<input type="checkbox"/> Mammogram _____	
<input type="checkbox"/> Polio _____	<input type="checkbox"/> Colonoscopy/Sigmoid _____	
<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> EKG _____	
<input type="checkbox"/> Hepatitis A/B _____	<input type="checkbox"/> Chest X-Ray _____	
<input type="checkbox"/> Flu _____	<input type="checkbox"/> PSA _____	
<input type="checkbox"/> Pneumovax _____	<input type="checkbox"/> Dexa/bone density _____	
<input type="checkbox"/> Prevnar 13 _____	<input type="checkbox"/> TB Skin Test _____	
<input type="checkbox"/> Zostavax _____	<input type="checkbox"/> Cholesterol _____	
<input type="checkbox"/> Shingrix _____	<input type="checkbox"/> Hepatitis C Screen _____	
<input type="checkbox"/> Gardasil _____		

## B. General

	Yes	No
Do you worry a lot about your health?	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually feel tired or worn out?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel depressed a lot of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently noticed that heat or warm weather bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently been drinking more water or fluids?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any unusual weight gain or loss recently?	<input type="checkbox"/>	<input type="checkbox"/>

## C. Skin

	Yes	No
Have you noticed:		
any change in the color of your skin?	<input type="checkbox"/>	<input type="checkbox"/>
any skin rashes or itching?	<input type="checkbox"/>	<input type="checkbox"/>
unusually dry skin?	<input type="checkbox"/>	<input type="checkbox"/>
any growth on your skin that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
any sores or wounds that do not heal?	<input type="checkbox"/>	<input type="checkbox"/>
any change in color or size of warts?	<input type="checkbox"/>	<input type="checkbox"/>

## D. Eyes

	Yes	No
Have you had:		
any pain in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision?	<input type="checkbox"/>	<input type="checkbox"/>
halos around lights?	<input type="checkbox"/>	<input type="checkbox"/>
change in vision?	<input type="checkbox"/>	<input type="checkbox"/>

## E. ENT

	Yes	No
Do you have:		
any trouble hearing?	<input type="checkbox"/>	<input type="checkbox"/>
ringing or buzzing in your ears?	<input type="checkbox"/>	<input type="checkbox"/>
earaches or discharge from your ears?	<input type="checkbox"/>	<input type="checkbox"/>
a lot of nasal stuffiness?	<input type="checkbox"/>	<input type="checkbox"/>
drainage down the back of your throat?	<input type="checkbox"/>	<input type="checkbox"/>
frequent or severe nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>
a lump in your throat?	<input type="checkbox"/>	<input type="checkbox"/>
a sore tongue or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
bleeding gums?	<input type="checkbox"/>	<input type="checkbox"/>

## F. Respiratory

	Yes	No
Do you have:	<input type="checkbox"/>	<input type="checkbox"/>
frequent chest colds?	<input type="checkbox"/>	<input type="checkbox"/>
a constant or bothersome cough?	<input type="checkbox"/>	<input type="checkbox"/>
coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>
sputum or phlegm between colds?	<input type="checkbox"/>	<input type="checkbox"/>
difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any wheezing or whistling in your chest?	<input type="checkbox"/>	<input type="checkbox"/>

## G. Cardiovascular

	Yes	No
Do you have pain, tightness or pressure in the front of your chest?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is it when walking fast, working hard or when excited?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that your electrocardiogram was abnormal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have swelling of your feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/>
Does your heart ever beat fast or irregular?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cramps in the calf muscles when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever awaken at night with severe difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>

## H. Gastrointestinal

	Yes	No
Have you recently had any changes in your eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc?	<input type="checkbox"/>	<input type="checkbox"/>
Do you tend to burp a lot?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently noted any trouble swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of indigestion or heartburn?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever vomited blood?	<input type="checkbox"/>	<input type="checkbox"/>
Are you bothered with constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent loose stool or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Do you pass a lot of gas?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever awaken at night with the feeling of fullness underneath your breast bone?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed blood from your rectum?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had black or tarry stools?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any recent changes in your bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take laxatives regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent nausea and/or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>

## I. GENTOURINARY

Do you have:		
anything wrong with your genitals?	<input type="checkbox"/>	<input type="checkbox"/>
burning or pain when you urinate?	<input type="checkbox"/>	<input type="checkbox"/>
to pass water frequently?	<input type="checkbox"/>	<input type="checkbox"/>
to pass more water than you use to?	<input type="checkbox"/>	<input type="checkbox"/>
to get up at night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
trouble with losing urine when you cough or sneeze?	<input type="checkbox"/>	<input type="checkbox"/>
a problem dribbling urine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed blood in your urine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	<input type="checkbox"/>	<input type="checkbox"/>
Men, do you have prostate gland trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
What type? _____		
Are you currently sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Estimated lifetime total of sexual partners _____		
If under age 50, do you use contraception?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever used other birth control measures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a poor libido?	<input type="checkbox"/>	<input type="checkbox"/>

## Notes:

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