MEDICAL HISTORY

Name_____ Date of Birth_____

Date_____

Medical History: To be filled out by patient and reviewed by your physician. Information on the history and physical examination is confidential and released only to persons you authorize in writing.

Allergies to Medication _____

Past Medical History
Major Illnesses (list, date) _____
Surgeries (appendix, tonsils, gallbladder, hysterectomy, etc, date) _____
Hospitalizations (list, date) _____
Accidents/Injuries (list, date) _____
Current Medications and dosages _____
_____
_____

Immunizations
Date of last tetanus _____
Date of Pneumococcal _____
Date of Hepatitis B vaccine _____

Habits
Smoking _____ packs per day. Use of chewing tobacco _____
Alcohol _____ drinks per day.
Drugs _____ type; _____ frequency of use
Diet _____ number of meals per day
Exercise _____ hours/week; _____ type of exercise
Do you use seatbelts? _____ Do you use sunscreen? _____
Do you use a bicycle helmet? _____
Any special dietary restrictions? _____

Social History
School _____Occupation _____
Outside activities_____ Marital status _____
Who lives in your home? _____ Do you feel safe at home? _____

Travel
Have you been outside the US? _____
If so, where? _____
When? _____

Family History

	√ Living	√ Age of Death	Medical Problems of this Relative
Father			
Mother			
Siblings			

Who in your family has had (Please list relationship, i.e. mother/father/MGM-maternal grandmother, etc.) :

Diabetes	Seizures	Migraine	Other cancer
Kidney disease	Tuberculosis	Breast cancer	Stroke
Heart attack	Angina	Intestinal cancer	Ulcers
High blood pressure	Alcoholism	High cholesterol	Thyroid disease
Hepatitis	Asthma	Osteoporosis	Gallstones
Depression/mood disorder		Other _____	

Occupational Exposures (asbestos, etc.):

Procedures: **Year**

Colonoscopy _____
Mammogram _____
Pap spear _____

-OVER-

Review of Systems (Please put a √ for any question that pertains to you at this time.)

General	Recent change in weight	Change in appetite	Have you ever put drugs in your veins
	Fatigue	Fever	Weakness
	Nervousness/anxiety	Depression	Do you have any risk factors for AIDS?
	Insomnia	Do you think you have an eating disorder?	Have you ever vomited for weight control?
	_____ What is your desired weight?		
Skin	Rashes	Lumps	Itching
	Changes in hair or nails	Changes in color or size of mole	Unusual skin moles/growths
Head	Headaches	Head Injury	
Eyes	_____Date of last eye exam	Difficulty with vision	Glasses or contact lenses
	Pain	Redness	Double vision
	Glaucoma		
Ears	Decreased hearing	Ringing	Dizziness
	Earache	Infection	Discharge
	Perforation	Hearing aid used	
Nose & Throat	_____Date of last dental exam	Bleeding gums	Nose bleeds
	Frequent sore throats	Hoarseness	Sores in mouth
	Sinus problems		
Neck	Lumps	History of radiation to thyroid gland	
Breasts	Lumps	Pain	Nipple discharge
Respiratory		Cough	Sputum
	Wheezing	Asthma	Blood in sputum
	Pneumonia	Short of breath	Bronchitis
Cardiac	Heart Murmur	High blood pressure	Chest pain
	Shortness of breath	Skipped beats	
GI	Trouble swallowing	Vomiting	Nausea
	Bulimia	Change in bowel habits	Blood in stool
	Black stool	Constipation	Diarrhea
	Use of laxatives	Hepatitis	Anorexia
	Hernia	Barium enema/Colonoscopy	
Urinary	Frequency	Urgency	Burning
	Urinating at night	Blood in urine	Hesitancy
	Urinary infections	Stones	Incontinence
Musculo skeletal	Joint pain	Joint stiffness	Back pain
Neuro	Fainting	Blackouts	Seizures
Endocrine	Thyroid trouble	Heat or cold intolerance	Diabetes
	Excess thirst	Excess hunger	Excess urination
Heme	Anemia	Have you ever had a blood transfusion?	Bleeding tendency
Male	Discharge from penis	Sores on penis	Do you use condoms every time you have intercourse?
	Testicular pain	Testicular masses	
	Sex with men	History of sexually transmitted diseases	
	_____ How often do you examine your testicles for masses?		
Female	_____ Age menses began	Menses every _____ days	_____ Days of bleeding
	_____ Date of last menses	Spotting between periods	_____ Date of last bone density
	_____ # of pregnancies	Itching	History of sexually transmitted disease?
	_____ # of deliveries	DES exposure	Vaginal discharge
	_____ # of abortions (spontaneous or induced)		Are condoms used every time you have intercourse?
	_____ Birth control method	_____ How often do you examine your breasts?	

REVIEWED BY: _____ **DATE:** _____