

Date: _____

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ DOB: ____/____/____ Age: ____

Weight: ____ BP: ____ Temp: ____ Pulse: ____ Allergies: _____

Past Medical History

Blood clotting	Yes	No	Thyroid Problems	Yes	No
Diabetes	Yes	No	Cancer [Type] _____		
Stroke	Yes	No	Arthritis/Gout	Yes	No
Hepatitis	Yes	No	Venereal Disease	Yes	No
Lupus (SLE)	Yes	No	C.R.E.S.T. Syndrome	Yes	No
Scleroderma	Yes	No	Rheumatoid Arthritis	Yes	No
Ulcerative Colitis	Yes	No	Crohn's Disease	Yes	No
Heart Attack	Yes	No	High Blood Pressure	Yes	No
Glaucoma	Yes	No	Pregnant # Times _____		Delivered _____
High Cholesterol	Yes	No	Congestive Heart Failure	Yes	No
Other: _____					

Previous Surgeries/Hospitalizations:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

 Tobacco Usage: YES NO Packs per Day: _____ # of Years: _____ Date Quit: _____
 Alcohol Usage: YES NO Amt: _____ Date Quit: _____
 Drug Usage: YES NO Amt: _____ Date Quit: _____

Marital Status: _____ Occupation: _____

Family History

	Alive _____	Deceased _____	Cause of death _____
1. Father	Alive _____	Deceased _____	_____
2. Mother	Alive _____	Deceased _____	_____
3. Father's Father	Alive _____	Deceased _____	_____
4. Father's Mother	Alive _____	Deceased _____	_____
5. Mother's Father	Alive _____	Deceased _____	_____
6. Mother's Mother	Alive _____	Deceased _____	_____
7. Brothers/Sisters	# Alive _____	# Deceased _____	_____

DATE PHYSICIAN REVIEWED AND/OR AMENDED FORM:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PLEASE COMPLETE BACK →

Review of Systems

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Wt Loss	Yes	No
Appetite Loss	Yes	No
Headache	Yes	No
Weakness	Yes	No
Loss of Energy	Yes	No

Allergic/Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No

Gastrointestinal

Abdominal Pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Indigestion	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood from rectum	Yes	No

Cardiovascular

Chest Pain	Yes	No
Leg Pain- walk	Yes	No
Swelling of Lower Extremities	Yes	No

Psychological

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you considered suicide?	Yes	No
Nervousness	Yes	No

Endocrine

Excessive Thirst	Yes	No
Chills	Yes	No
Tiredness	Yes	No

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/tingling	Yes	No
Extremity Weakness	Yes	No
Seizures	Yes	No
Excessive Thirst	Yes	No
Too hot/cold	Yes	No
Tired/ Sluggish	Yes	No

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No
New/changing spots	Yes	No

Respiratory

Wheezing	Yes	No
Short of Breath	Yes	No
Cough	Yes	No

Musculoskeletal

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No

Ears/Nose/Throat/Mouth

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problems	Yes	No
Hearing Disturb	Yes	No

Genitourinary

Urine Retention	Yes	No
Painful Urination	Yes	No
Urinary Frequency	Yes	No
Blood in Urine	Yes	No
Leaking Urine	Yes	No
Prostate Problems	Yes	No

GYN

Last Normal Menses	_____	
Vaginal Discharge	Yes	No
Endometriosis	Yes	No

Hematologic/Lymphatic

Swollen glands	Yes	No
Blood clotting problem	Yes	No
Frequent Infections	Yes	No

Screening Test History (approx. date of last exam)

Chest X-Ray _____
Mammogram _____
Pelvic exam/PAP smear _____
Colonoscopy/Sigmoidoscopy _____
Prostate Exam/PSA _____

Immunization History (approx. date of last injection)

Flu Vaccine _____
Pneumonia Vaccine _____
Tetanus Shot _____
Hepatitis Vaccine _____

Have you ever been exposed to (please circle): Asbestos/ Chemicals/Ionizing Radiation?