PATIENT MEDICAL HISTORY

Name ____ PATIENT LABEL

Patient # ____

Date ____

D.O.B. ________________________________ Age _________________ Height ____________________ Weight _____________________

Confidential Record: The information contained herein will not be released unless you have authorized us to do so.

Who is your Primary Care Doctor?
Name and Group ____

Address ____

Referring Doctor ____

Reason for your visit: ____

____

____

Past Medical History:
Check if **you** have had any of the following medical problems

- ❑ Autoimmune Disease
- ❑ Breast Problem
  Describe: ________________
  ____
- ❑ Previous Breast Biopsies?
  Results: ______________
  ____
- ❑ Skin Diseases
  Type: _______________
- ❑ High Blood Pressure
- ❑ Anemia
- ❑ Heart Disease
  - ❑ **Angina**
  - ❑ **Heart Attack**
  - ❑ **Heart Failure**
  - ❑ **Irregular Rhythm**
  - ❑ **Heart Murmur**
  - ❑ **Mitral Valve Prolapse**
  - ❑ **Rheumatic Fever**
- ❑ **Stroke**
- ❑ Lung Disease
  - ❑ **Tuberculosis**
  - ❑ **Emphysema**
  - ❑ **COPD**
  - ❑ **Asthma**
  - ❑ **Bronchitis**
- ❑ Blood Clots/Bleeding Disorder
- ❑ Peripheral Vascular Disease
- ❑ Depression / Mental Illness
- ❑ Gout
- ❑ Migraine Headaches
- ❑ Cancer
  Type ______________
  Treatment:
  - ☐ Radiation
  - ☐ Chemotherapy
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Glaucoma
- ❑ Vision Problems
- ❑ Artificial Eye
- ❑ Dentures
- ❑ Caps, Crowns, Bridges
- ❑ Loose Teeth
- ❑ Hearing Loss
- ❑ Fibromyalgia
- ❑ Gastrointestinal
  - ❑ **Ulcers**
  - ❑ **Diverticulosis / Diverticulitis**
  - ❑ **GERD**
  - ❑ **Hiatal Hernia**
  - ❑ **Crohn's Disease**
  - ❑ **Ulcerative Colitis**
  - ❑ **Irritable Bowel**
  - ❑ **Jaundice**
  - ❑ **Hepatitis**
- ❑ Kidney Disease
  - ❑ **Dialysis**
  Schedule: M T W Th F
  - ❑ **Stones**
- ❑ **Allergies**
- ❑ **Scleroderma**

Operations: List and indicate approximate dates
____
____
____
____
____

Date of most recent general anesthesia:
____

Have you ever had any problems with general anesthesia?
❑ Yes ❑ No
Describe: __________________________________
____

Do you have any family history of problems with general anesthesia ❑ Yes ❑ No
Describe: __________________________________
____

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

Serious Injuries (other than above): List and give approximate dates
____
____
____
____

List any of your medical problems not covered above or provide details for those checked above: ____
____
____
____
____
____

Women: Number of pregnancies: _________
Number of live births: ___________________
Number of Miscarriages/abortions: ________
Your age at first live birth: _______________
Your age at first menstrual cycle: _________
Do you take oral contraceptives: ❑ Yes ❑ No
Do you take Hormones? ❑ Yes ❑ No

PATIENT'S NAME: ____

Medications:

Please list all medications and dosages, including vitamins, dietary supplements, herbal remedies, and over-the-counter medications.

Do you take Aspirin? ❑ **Yes** ❑ **No** ____

Do you take Blood Thinners: ❑ Yes ❑ No ____

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list medications and the reaction that you have to them:

____

____

Any history of Steroid use? ❑ Yes ❑ No If yes, when? ____________________________________

Social History & Personal Habits:

Occupation: ____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Check if you regularly drink alcohol: ❑ Yes ❑ No

If "yes":
❑ Hard Liquor: ❑ 1 – 3 oz. per day ❑ Over 3 oz. per day
❑ Wine: ❑ 1 glass per day ❑ 2 glasses ❑ 3 or more
❑ Beer: ❑ 1 bottle per day ❑ 2 bottles ❑ 3 or more

Do you smoke? ❑ Yes ❑ No

If "yes", number of cigarettes per day: ________

For how many years? ______________________

Do you have a history of street drug use? ❑ Yes ❑ No

Have you ever required a blood transfusion? ❑ Yes ❑ No

Are you concerned that you may be at risk for HIV? ❑ Yes ❑ No

Family History:

	Circle Gender	Age	Medical Problems	If Deceased: Age at Death	Cause
Father					
Mother					
Brothers / Sisters	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				

Do any of the following run in your family?

- ❑ Heart Disease
- ❑ Bleeding Disorder
- ❑ Cancer

❑Type ______________________________ ❑ Type ______________________________

❑ Type ______________________________ ❑ Type ______________________________

PATIENT NAME ______________________________________

Review of Systems: *Please indicate if you have experienced any of the following symptoms* ***in the past 6 months:***

General	**Yes**	**No**
Have you recently experienced fevers, chills, or sweats?	❑	❑
Has there been any unusual weight gain or loss recently?	❑	❑
Any change in appetite?	❑	❑
Do you regularly have trouble sleeping?	❑	❑
Skin		
Have you noticed any of the following:		
Any growth on your skin that bothers you?	❑	❑
Any change in color or size of moles?	❑	❑
EENT		
Do you have frequent or severe nosebleeds?	❑	❑
Change in vision?	❑	❑
Lymphatic		
Any swollen glands or lymph nodes?	❑	❑
Endocrine		
Any hot / cold intolerance?	❑	❑
Frequent urination?	❑	❑
Excessive thirst?	❑	❑
Other glandular problem:	❑	❑
Specify: ____		
Respiratory		
Do you have persistent or bothersome cough?	❑	❑
Shortness of breath or difficulty breathing?	❑	❑
Do you cough up blood?	❑	❑
Cardiovascular		
Do you have pain, tightness, or pressure in your chest?	❑	❑
Swelling in your feet or ankles?	❑	❑
Pain in the calf muscle or buttocks when you walk?	❑	❑
Any irregular heartbeat?	❑	❑
Difficulty lying flat to sleep?	❑	❑

Gastrointestinal	**Yes**	**No**
Do you have a lot of indigestion or heartburn?	❑	❑
Do you have any problem swallowing?	❑	❑
Do you have frequent nausea / vomiting?	❑	❑
Are you persistently bothered with constipation?	❑	❑
Do you frequently have loose stools/diarrhea?	❑	❑
Have you noticed recent changes in bowel movements?	❑	❑
Blood in your stool?	❑	❑
Genitourinary		
Do you have burning or pain during urination?	❑	❑
Have you ever passed blood in your urine?	❑	❑
Do you have difficulty urinating?	❑	❑
Musculoskeletal		
Do you have joint pain, stiffness, or swelling?	❑	❑
Central Nervous System	❑	❑
Do you have frequent or severe headaches?	❑	❑
Have you ever had convulsions or seizures?	❑	❑
Women ONLY:		
Are you currently having menstrual periods?	❑	❑
Are your menstrual periods irregular?	❑	❑
Have you passed menopause or "change of life"?	❑	❑
If "yes" what was your age at Menopause? __________		
Do you have hot flashes or vaginal dryness?	❑	❑
Have you have any lumps in your breasts?	❑	❑
Have you had any discharge from your nipples not associated with pregnancy or breastfeeding?	❑	❑
Do you have any breast pain?	❑	❑
Do you leak urine when you cough, sneeze or laugh?	❑	❑

Health Maintenance:

Please note the approximate **date** and **result** of you most recent:

Complete Physical Exam ❑ Never
Date: ____________________ Results: ________________

Treadmill Stress Test ❑ Never
Date: ____________________ Results: ________________

Hemoccult ❑ Never
Date: ____________________ Results: ________________

Sigmoidoscopy / Colonoscopy ❑ Never
Date: ____________________ Results: ________________

Women:

Pap Smear ❑ Never
Date: ______________________ Results: ______________________

Mammogram ❑ Never
Date: ______________________ Results: ______________________

Do you perform Self Breast Exams? ❑ Yes ❑ No

Men:

Prostate Examination ❑ Never
Date: ______________________ Results: ______________________

Thank you for your complete and honest answers to these important health questions. All of this information will be kept confidential by your health care providers. By signing below, you certify that the information above is true to the best of your knowledge.

______________________ ______________________ ______________________

Patient Signature Physician Signature Date