Patient Medical History Form

Name				**Today's Date**
Gender (Sex)	☐ Male ☐ Female		**Age**	**Birth Date** (mm/dd/yyyy)
Marital Status	☐ Single ☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Currently Living	☐ Alone ☐ With Family	☐ With Friends	☐ With Significant Other	
Profession (Job)	☐ Working, Employed By:			☐ Retired

Health History

Check (v) all items either No or Yes	No	Yes, Now	Yes, Past
Abnormal EKG			
Alcoholism			
Anemia or Low Blood			
Anxiety			
Arthritis or Sore Joints			
Asthma or Hay Fever			
Bleeding or Bruising			
Broken Bones			
Bronchitis or Emphysema			
Cancer			
Cataracts			
Chemical Dependency			
Chest Pain			
Circulation Problems			
Deafness or Dizziness or Ringing Ears			
Depression or Sadness			
Diabetes			
Difficulty Sleeping or Lie Awake at Night			
Ear Infections			
Epilepsy or Seizures			
Fatigue or Tiredness or Weakness			
Forgetful			
Gall Stones			
Glaucoma			
Gout			
Head Injury			

Check (v) all items either No or Yes	No	Yes, Now	Yes, Past
Headaches (Frequent)			
Heart Attack or Heart Disease			
Heart Murmur			
Hemorrhoids or Rectal Problems			
Hepatitis Type A, B or C (circle)			
Hernia			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Jaundice			
Kidney or Bladder Problems			
Leg or Foot Pain			
Liver Disease			
Night Sweats			
Phlebitis or Blood Clots			
Psychiatric Care			
Sexually Transmitted Disease			
Shortness of Breath			
Sinus Trouble			
Skin Disease or Psoriasis or Eczema			
Stomach Problems or Ulcers			
Stool or Bowel Problems			
Stroke			
Thyroid Problem			
Tuberculosis or Positive TB Test			
Weight Loss or Gain (circle one)			

Habits

Do you:		If Yes, how much?
Smoke Tobacco	☐ No ☐ Yes	Packs/Day
Chew Tobacco	☐ No ☐ Yes	Tins or Bags/Day
Drink Caffeine	☐ No ☐ Yes	Cups/Day
Drink Alcohol or Wine	☐ No ☐ Yes	Drinks/Day
Drink Beer	☐ No ☐ Yes	Cans/Day
Gamble	☐ No ☐ Yes	
Use Street Drugs	☐ No ☐ Yes	
Exercise	☐ No ☐ Yes	

Medications

Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Immunizations

Flu Shot	☐ No ☐ Yes	Date
Hepatitis B	☐ No ☐ Yes	Date
MMR	☐ No ☐ Yes	Date
Pneumonia	☐ No ☐ Yes	Date
Tetanus	☐ No ☐ Yes	Date

Allergies

List anything that you are allergic to (medications, foods, bee sting, etc.) and how each affects you.

1.	Reaction:
2.	Reaction:
3.	Reaction:
4.	Reaction:
5.	Reaction:

Hospitalizations (not including normal pregnancies)

1.	Year
2.	Year
3.	Year
4.	Year

Serious Illness (not requiring hospitalization)

1.	Year
2.	Year
3.	Year
4.	Year

Family History

Check (v) either No or Yes. If Yes, please check (v) the family member who has (or in the past had) any of the medical problems listed.		Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Alcoholism	☐ No ☐ Yes							
Allergies	☐ No ☐ Yes							
Anemia	☐ No ☐ Yes							
Arthritis	☐ No ☐ Yes							
Asthma or Hay Fever	☐ No ☐ Yes							
Birth Defects	☐ No ☐ Yes							
Cancer	☐ No ☐ Yes							
Colon or Bowel Problems	☐ No ☐ Yes							
Congenital Heart Defects	☐ No ☐ Yes							
Diabetes	☐ No ☐ Yes							
Emphysema	☐ No ☐ Yes							
Epilepsy	☐ No ☐ Yes							

Check (v) either No or Yes. If Yes, please check (v) the family member who has (or in the past had) any of the medical problems listed.		Father	Mother	Brother	Sister	Son	Daughter	Grandparent
High Blood Pressure	☐ No ☐ Yes							
Kidney Disease	☐ No ☐ Yes							
Leukemia	☐ No ☐ Yes							
Liver Disease	☐ No ☐ Yes							
Mental Illness	☐ No ☐ Yes							
Migraines	☐ No ☐ Yes							
Nervous Breakdown	☐ No ☐ Yes							
Obesity	☐ No ☐ Yes							
Rheumatic Fever	☐ No ☐ Yes							
Sickle Cell Anemia	☐ No ☐ Yes							
Stomach Problems or Ulcer	☐ No ☐ Yes							
Stroke	☐ No ☐ Yes							

Men Only

Pain or lump(s) in testicles?		☐ No ☐ Yes
Penile (penis) itching, burning or discharge?		☐ No ☐ Yes
Prostate disease or problems?		☐ No ☐ Yes
Problems starting or stopping your urine stream?		☐ No ☐ Yes
Wake in the night to go to the bathroom?		☐ No ☐ Yes
Sexual problems or concerns?		☐ No ☐ Yes
Do you feel safe in your home?		☐ No ☐ Yes
Do you have a Living Will?	☐ No ☐ Yes	Where?
If No, would you like information on Living Wills?		☐ No ☐ Yes

Women Only

Last Pap Smear		Abnormal?	☐ No ☐ Yes
Last Mammogram		Abnormal?	☐ No ☐ Yes
Age Periods Started		Problems?	☐ No ☐ Yes
Ovarian Cysts			☐ No ☐ Yes
Sexual problems or concerns?			☐ No ☐ Yes
Vaginal itching, burning or discharge?			☐ No ☐ Yes
Wake in the night to go to the bathroom?			☐ No ☐ Yes
Breast disease or nipple discharge?			☐ No ☐ Yes
Pregnancies	#	Births	#
Miscarriages	#	Abortions	#
Birth Control Method:			
Do you feel safe in your home?			☐ No ☐ Yes
Do you have a Living Will?	☐ No ☐ Yes	Where?	
If No, would you like information on Living Wills?			☐ No ☐ Yes

The information on this Patient Health History Form is correct to the best of my knowledge.

Patient or Guardian Signature _____ **Date** _____

Physician Signature _____ **Date** _____

Systems Review *Please circle issues that you are CURRENTLY experiencing*

Metabolic System

Weight change _____
Warmer / Colder than others _____
Increased sweating _____
Goiter _____
Increased thirst _____
Increased urination _____
Skin, hair, nail changes _____

Head, Eyes, Ears, Nose, Throat

Headache _____
Hearing problem _____
Eye problem _____
Ear pain _____
Dizziness _____
Nasal drainage _____
Sore mouth / throat _____

Cardiovascular

Chest pain _____
Fast / irregular heartbeat _____
Ankle swelling _____
High blood pressure _____
Calf pain with walking _____

Respiratory

Short of breath _____
Wheezing _____
Raise phlegm _____
Cough up blood _____

Urinary

Blood in urine _____
Urinary frequency _____
Pain / burning with urination _____
Empty bladder at night _____
Bladder leakage _____

Female Patients -

Spot or menstruate: _____Yes _____ No
Every _____ days, for _____ days each period
Age of onset _____ Menopause _____
Last period _____ Last PAP smear _____
Breast changes _____
Calcium intake _____
Do you do self breast exam? _____ Yes _____ No
Number of pregnancies?_____

Male Patients -

Impotence _____
Changes in urinary stream_____
Testicular exam?_____ Scrotal lumps _____

Gastro-Intenstinal

Heartburn _____
Nausea / vomiting _____
Trouble swallowing _____
Abdominal pain _____
Blood in stools _____
Jaundice _____
Change in bowel habit _____
Constipation _____
Diarrhea _____
Belching / gas _____
Hemorrhoids _____

Musculoskeletal / Neuro / Psychiatric

Back pain _____
Joint pain _____
Stiff neck _____
Muscle weakness / paralysis _____
Tremor / shakes _____
Numbness / tingling _____
Convulsions _____
Fainting _____
Depression / anxiety _____
Stress _____
Sleep poorly _____

Blood / Lymphatic / Constitutional

Bleeding / Bruising _____
Anemia _____
Enlarged glands _____
Fever _____

Allergic / Immunologic

Hayfever _____
Asthma _____
Rashes / hives _____
Allergies _____

Vaccines:

Tetanus No____ Yes (when) _____
Pneumonia No____ Yes (when) _____
Hepatitis B No____ Yes (when) _____
Flu No____ Yes (when) _____
MMR No____ Yes (when) _____

Please list other people in your household:

_____
_____
_____
_____

REMARKS:_____
_____
_____
_____

If you are interested in information in Living Wills and Durable Power of Attorney for Health Care Decisions, please ask your physician.