

PATIENT MEDICAL HISTORY

Name of Patient: _____ How did you become aware of this office?
Date of Birth: _____
Appointment Date: _____

Reason For Visit

Problem/Condition: _____

When did this problem begin? _____

Were you referred to us by another physician? Yes / No If yes,
Please indicate physician's name: _____

Address: _____

May we send a letter about your evaluation and treatment? Yes / No

Medical History

Do you have or have you ever had any of the following?

| | | | | |
|--------------------------|----------|---------------------|----------|---------------|
| Past blood transfusions | Yes / No | Heart Disease | Yes / No | |
| Diabetes or hypoglycemia | Yes / No | High blood pressure | Yes / No | |
| Liver disease/jaundice | Yes / No | Thyroid problems | Yes / No | |
| History of tuberculosis | Yes / No | Hepatitis | Yes / No | |
| History of kidney stones | Yes / No | Bleeding problems | Yes / No | Height: _____ |
| | | History of cancer | Yes / No | Weight: _____ |

Allergies to medications? Yes / No If yes, please list: _____

Previous Surgeries

| <u>Year</u> | <u>Surgery</u> | <u>Reason</u> | <u>Problems</u> |
|-------------|----------------|---------------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

For Physician Use:

Reviewed with patient by: _____ Date: _____

Any other medical conditions? Yes / No If yes, please explain:

When were you last seen by a physician? _____
Reason for that visit? _____

Please list all medications you are taking:

| <u>Medication</u> | <u>Dose</u> | <u>Reason for Taking</u> |
|-------------------|-------------|--------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Review of Systems

Circle

Do you currently have any of the following?

| | | |
|----------------|--|----------|
| CONSTITUTIONAL | High blood pressure, fast/slow heart rate? | Yes / No |
| ENT | Hearing loss, nosebleeds, lumps in the neck? | Yes / No |
| EYES | Failing vision or double vision? | Yes / No |
| ENDOCRINE | Heat intolerance, weight loss/gain? | Yes / No |
| HEART | Chest pain, irregular heart beats? | Yes / No |
| HEMATOLOGIC | Bleeding disorder, blood clots? | Yes / No |
| G.I. | Stomach pain, nausea, vomiting, diarrhea or bleeding? | Yes / No |
| G.U. | Burning, bleeding, pain or other problems passing urine? | Yes / No |
| | Female: Currently pregnant? | Yes / No |
| LUNGS | Frequent cough or shortness of breath? | Yes / No |
| N.S. | Convulsions, seizures or memory loss? | Yes / No |
| SKIN | Skin rash or ulcers? | Yes / No |
| OTHER | Any other item not mentioned above? | Yes / No |

Social History

Occupation: _____ No. of years: _____

Do you smoke? Yes / No If yes, amount per day: _____ Years: _____

Do you consume alcohol? Yes / No If yes, frequency: _____

History of IV drug abuse or other HIV/AIDS risk factors: _____

Family History

Do you have a family history of:

| | | | |
|------------------------|----------|----------|----------|
| Heart Disease | Yes / No | Stroke | Yes / No |
| High Cholesterol Level | Yes / No | Cancer | Yes / No |
| High Blood Pressure | Yes / No | Diabetes | Yes / No |
| Allergies | Yes / No | Asthma | Yes / No |