

# MEDICAL HISTORY

Today's Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_

What is your approximate height? \_\_\_\_\_

Weight? \_\_\_\_\_

Reason for seeing the doctor today:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List major illnesses or medical problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all operations (give date and type):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications you are allergic to and the reaction you have:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PERSONAL HISTORY

Check any of the following you have had and when:

|                      | No                       | Yes                      | Date  |
|----------------------|--------------------------|--------------------------|-------|
| Pulmonary embolism   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Blood clots/DVT      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Rheumatic Fever      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Circulatory Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Murmur         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hepatitis            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chemotherapy         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Excess Bleeding      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diverticulosis       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pancreatitis         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Emphysema            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Jaundice             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cirrhosis            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Colitis              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ulcer                | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Epilepsy             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Anemia               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stroke               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hernia               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

## FAMILY HISTORY

|                          | No                       | Yes                      | Family Relationship<br><small>(Father, Mother, Brother, Sister, Grandparent)</small> |
|--------------------------|--------------------------|--------------------------|--|
| Pulmonary embolism       | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Blood clots/DVT          | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Diabetes                 | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Tuberculosis             | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Lung Disease             | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Heart Disease            | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Stroke                   | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Kidney Disease           | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| High Blood Pressure      | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Cancer                   | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Bleeding Tendency        | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Do you use alcohol?      | <input type="checkbox"/> | <input type="checkbox"/> |  |
| If yes, how often? _____ |                          |                          | How long? _____  |
| Do you use tobacco?      | <input type="checkbox"/> | <input type="checkbox"/> |  |
| If yes, amount _____     |                          |                          | How long? _____  |

## MEDICATION INFO

|                  | NAME | STRENGTH | DOSAGE |
|------------------|------|----------|--------|
| Prescribed       | 1.   |          |        |
|                  | 2.   |          |        |
|                  | 3.   |          |        |
|                  | 4.   |          |        |
|                  | 5.   |          |        |
| Over-the Counter | 1.   |          |        |
|                  | 2.   |          |        |
| Herbal           | 1.   |          |        |
|                  | 2.   |          |        |

Reviewed: \_\_\_\_\_

# REVIEW OF SYSTEMS

Please check if you have had any of these symptoms recently

**CONSTITUTIONAL**

**NO YES**

Recent change in weight    
 How many pounds?  
 Gained: \_\_\_\_\_  
 Lost: \_\_\_\_\_  
 Since when? \_\_\_\_\_

Loss of appetite    
 Fever    
 Fatigue    
 Night sweats

**HEAD**

Frequent headaches    
 Seizures    
 Head injury    
 (If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_)

**EYES**

Trouble with vision    
 Wear corrective lenses

**EARS, NOSE, AND THROAT**

Trouble hearing    
 Hoarse voice

**GASTROINTESTINAL**

Heartburn    
 Feel bloated after eating    
 Have difficulty swallowing    
 Nausea and vomiting    
 Have vomited blood    
 Constipation    
 Diarrhea    
 Black stools    
 Hemorrhoids    
 Rectal bleeding    
 Have pain in stomach    
 After eating?    
 Have pain elsewhere    
 In abdomen

**GENITO-URINARY**

Burning with urination    
 Blood in urine

**MUSCULOSKELETAL**

**NO YES**

Stiff or painful joints

Reviewed: \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**RESPIRATORY**

Shortness of breath

Coughing    
 Coughing up blood    
 Wheezing    
 Bronchitis more than once    
 per month

**CARDIOVASCULAR**

Chest pain, or tightness    
 Difficulty in breathing    
 Heart palpitations    
 Have you had a stress test?    
 (If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_)

**SKIN**

Changes in coloration of    
 your skin  
 Any lumps noticed:    
 Under your arms?  
 Groin area?    
 Breast?

**NEUROLOGIC**

Convulsions    
 Muscular weakness    
 Paralysis    
 Any loss of sensation, tingling,    
 numbness, in your fingers,    
 toes, limbs?

**MOOD**

Depressed?    
 Anxious?    
 Trouble sleeping?

**SLEEP**

Sleep Apnea    
 (If so, do you use CPAP?)    
 Date of last sleep study? \_\_\_\_/\_\_\_\_/\_\_\_\_