

Today's Date _____
 Updated On _____

PATIENT MEDICAL HISTORY

Name: _____ Birthdate: _____ Age: _____
Last First Middle (Month/Day/Year)

Describe symptoms (include date of onset) _____

What seems to make the problem worse? _____

What helps the problem? (include medications or treatments) _____

PERSONAL HISTORY OF ILLNESS: (Check any illness, past or present)

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout/Arthritis |
| <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Epilepsy (seizure) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin Trouble | <input type="checkbox"/> _____ |

SURGERIES AND HOSPITALIZATIONS

Year	Surgery or reason for hospitalization	Year	Surgery or reason for hospitalization
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	Have you ever had a: <input type="checkbox"/> CAT SCAN <input type="checkbox"/> MRI	
4. _____	_____	<input type="checkbox"/> EEG <input type="checkbox"/> EMG	

ALLERGIES

Are you allergic to any medications? Yes No If yes, what? _____
 Any other allergies? _____

MEDICATIONS

Please list name and dose of all present medications. (Include non-prescriptive drugs, birth control pills, and vitamins)

Medication	Dosage	Medication	Dosage
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

FAMILY HISTORY

Is there any history of the following diseases in your family? If yes, indicate which relative.

DISEASE	WHICH RELATIVE	DISEASE	WHICH RELATIVE
Alzheimer Disease	_____	Heart Disease	_____
Stroke	_____	High Blood Pressure	_____
Diabetes	_____	Drug/Alcohol Abuse	_____
Epilepsy	_____	Migraine Headache	_____
Depression	_____	Multiple Sclerosis	_____

(please turn the page)

SOCIAL HISTORY

Married Widowed Single Divorced Occupation: _____
 Children: No Yes - How many _____ Caffeine use: No Yes - How much _____
 Exercise: No Yes - How often _____ (coffee, tea, cola)
 Drug Use: No Yes - How often _____ Alcohol use: No Yes - How much _____
 (Marijuana, LSD, Speed, Heroin, Methamphetamine, etc.) (including beer and wine)
 Tobacco use: No Yes - How much _____

Do you have a Living Will/Advanced Directives? Yes No Do we have a copy? Yes No

If you have any of the following symptoms/conditions, put a check mark next to the symptoms/conditions.

Neurologic

- frequent headaches
- memory loss
- trouble concentrating
- double vision
- loss of vision
- numbness of body part
- muscle cramping/twitching
- tremor/shaking
- balance/coordination problem
- dizziness/lightheadedness
- blackouts/loss of consciousness
- seizure/convulsion
- loss of smell
- head injury
- trouble walking
- muscle weakness

General

- night sweats
- fever/chills
- trouble falling asleep
- trouble waking early
- weight gain
- poor appetite
- excessive fatigue

HEENT

- glaucoma
- cataracts
- double vision
- trouble hearing
- bleeding gums
- ringing in ears
- trouble swallowing
- choking spells
- sore tongue
- pain in throat/mouth
- other ear problems
- other eye problems
- sinus trouble
- nosebleeds
- persistent hoarseness

Cardiovascular

- low/high blood pressure
- heart attack
- heart failure
- irregular heart beat/palpitations
- chest pain

- swollen ankles
- heart murmur
- problem with heart valve
- rheumatic fever

Respiratory

- tuberculosis
- emphysema
- coughing up blood
- shortness of breath
- pneumonia
- bronchitis
- asthma/wheezing

Gastrointestinal

- belching
- nausea
- bloating
- vomiting
- ulcer
- diarrhea
- colitis
- stomach pain
- vomiting blood
- blood in stools
- black tarry bowel movements
- hemorrhoids
- gallstones
- constipation
- loss of control of bowel
- hepatitis
- yellow jaundice
- other liver trouble
- appendicitis

Genitourinary

- frequent urination
- trouble starting/stopping urination
- burning with urination
- loss of control of urination
- frequent or recurrent bladder or kidney infection
- urination at night
- blood in urine
- kidney stones
- other kidney trouble
- sexual problems
- gonorrhea
- syphilis

- venereal disease
- discharge from or sores on genitals

Musculoskeletal

- joint pain
- redness/swelling of joints
- back/neck pain
- arthritis
- gout
- leg cramps
- slipped disc

Skin and/or Breast

- hair loss
- excessive hair growth
- rash
- skin trouble/changes
- breast lumps

Endocrine

- increased thirst
- diabetes (sugar)
- thyroid trouble
- miscarriage
- irregular menstrual cycle
- infertility

Hematologic/Lymphatic

- easy bruising/bleeding
- blood clots
- anemia (low blood count)
- sickle cell disease
- transfusions
- enlarged glands

Allergic/Immunologic

- hay fever
- frequent colds
- HIV positive

Psychiatric

- depression
- excessive worry
- thoughts of suicide
- other emotional problems
- anxiety
- treatment by psychiatrist or psychologist
- chemical dependency treatment
- mood swings

Signature: _____ Date: _____