MEDICAL HISTORY FORM

Patient's Name_____ How do you want us to address you? _____
DOB _____ Age_____ Height _____ Weight _____ Referring Dr._____
Why are you here to see the doctor? _____

MEDICATIONS

MEDICATIONS TAKEN REGULARLY	REASON	DOSE	How Often?	Start Date

MEDICINE ALLERGIES	REACTION
FOOD ALLERGIES	**REACTION**

PROCEDURE/SURGERY	Side	YEAR

Have you had a colonoscopy? _____ If so approximately when? _____
Have you had a mammogram? _____ If so approximately when? _____

PAST MEDICAL HISTORY

DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO
Anemia	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Skin Cancer	☐	☐
Bleeding Problem	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	High Blood pressure	☐	☐	Thyroid Disease	☐	☐
Cancer (Other)	☐	☐	HIV/AIDS	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Kidney Disease	☐	☐			

If yes to any of the above, please describe the condition: _____
_____

YOUR FAMILY HISTORY

DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO
Breast Cancer	☐	☐	Diabetes	☐	☐	Heart Disease	☐	☐
Melanoma	☐	☐	Stroke	☐	☐	Kidney Disease	☐	☐
Other Cancer	☐	☐	High Blood Pressure	☐	☐	Depression	☐	☐

If yes to any of the above, please identify your relation to the family member and age of diagnosis: _____
_____

TOBACCO USE: ☐YES ☐NO ☐FORMER
Type _____ # of Years _____
Units per day _____ Year quit ____

DRINKS ALCOHOL: ☐YES ☐NO ☐FORMER
Type _____ Amount _____
Frequency _____ Last drink _____

EXERCISE: ☐YES ☐NO
Can you walk up 2 flights of stairs? ☐YES ☐NO

Occupation _____

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REVIEW OF SYSTEMS

Patient Name _____ Date _____

Are you currently experiencing any of the following?

HEENT	NO	YES	Gastrointestinal	NO	YES	Constitutional	NO	YES
Ear drainage	☐	☐	Abdominal pain	☐	☐	Chills	☐	☐
Ear pain	☐	☐	Blood in stools	☐	☐	Fatigue	☐	☐
Eye discharge	☐	☐	Change in stools	☐	☐	Fever	☐	☐
Eye pain	☐	☐	Constipation	☐	☐	Malaise	☐	☐
Hearing loss	☐	☐	Diarrhea	☐	☐	Night Sweats	☐	☐
Nasal drainage	☐	☐	Heartburn	☐	☐	Weight gain	☐	☐
Sinus pressure	☐	☐	Loss of appetite	☐	☐	Weight Loss	☐	☐
Sore throat	☐	☐	Nausea	☐	☐	Other:		
Visual changes	☐	☐	Vomiting	☐	☐			
Other:			Other:					

Neurological	NO	YES	Metabolic/endocrine	NO	YES	Integumentary	NO	YES
Dizziness	☐	☐	Brittle hair	☐	☐	Contact allergy	☐	☐
Extremity numbness	☐	☐	Brittle nails	☐	☐	Hives	☐	☐
Extremity weakness	☐	☐	Cold intolerance	☐	☐	Itching	☐	☐
Gait disturbance	☐	☐	Hair changes	☐	☐	Mole changes	☐	☐
Headache	☐	☐	Heat intolerance	☐	☐	Rash	☐	☐
Memory loss	☐	☐	Hirsutism	☐	☐	Skin Lesion	☐	☐
Seizures	☐	☐	Polydipsia	☐	☐	Other:		
Tremors	☐	☐	Polyphagia	☐	☐			
Other:			Other:					

Breast	NO	YES	Respiratory	NO	YES	Immunologic	NO	YES
Nipple discharge	☐	☐	Chronic cough	☐	☐	Environmental allergies	☐	☐
Breast lump	☐	☐	Cough	☐	☐	Food allergies	☐	☐
inverted nipples	☐	☐	Known TB exposure	☐	☐	Seasonal allergies	☐	☐
breast pain	☐	☐	Shortness of breath	☐	☐	Limited range of motion	☐	☐
breast swelling	☐	☐	Wheezing	☐	☐	Redness or tenderness	☐	☐
Other:			Other:			Other:		

Musculoskeletal	NO	YES	Cardiovascular	NO	YES	Genitourinary	NO	YES
Back pain	☐	☐	Chest pain	☐	☐	Painful/difficult urination	☐	☐
Joint pain	☐	☐	Claudication	☐	☐	Excessive urination	☐	☐
Joint swelling	☐	☐	Edema (swelling)	☐	☐	Blood in urine	☐	☐
Muscle weakness	☐	☐	Palpitations	☐	☐	incontinence	☐	☐
Neck pain	☐	☐	Other:			Other:		
Other:								

Psychiatric	NO	YES	HEMATOLOGIC/LYMPHATIC	NO	YES
Anxiety	☐	☐	Easy bleeding	☐	☐
Depression	☐	☐	Easy bruising	☐	☐
Insomnia	☐	☐	Lymphadenopathy (swelling of lymph nodes)	☐	☐
Other:			Other:		

PASTS TESTS/DIAGNOSTICS/LABS:	
DATE	**TYPE**

I have reviewed the above recorded information

Physician Signature _____ Date_____