# 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 |
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| MEDICINE ALLERGIES | REACTION |
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| **FOOD ALLERGIES** | **REACTION** |
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| PROCEDURE/SURGERY | Side | YEAR |
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**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** |
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I have reviewed the above recorded information

Physician Signature _____ Date_____