PATIENT MEDICAL HISTORY

Date:	Name:	Birthday:	Age:
Primary Care Physician:			
Physician who sent you:			

REASON FOR OFFICE VISIT:

Nurse Use: Height__________ Weight__________ Blood Pressure__________ Pulse__________ Temperature__________

CURRENT MEDICATIONS (If none- write 'None')

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

MEDICATION ALLERGIES (If none- write 'None')

1. Reaction:	2. Reaction:	3. Reaction:	4. Reaction:

PAST MEDICAL HISTORY: Check (√) all that apply

- □ Alcoholism
- □ Allergies
- □ Anemia
- □ Angina
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ Benign prostatic hypertrophy
- □ Bleeding Disorders
- □ Blood Clots
- □ Blood transfusion
- □ Cancer
- □ Cardiac arrest
- □ Cardiac dysrhythmias
- □ Cardiac valvular disease
- □ COPD
- □ Coronary artery disease
- □ Crohn's disease
- □ Dementia
- □ Depression
- □ Diabetes
- □ DVT
- □ Endocarditis
- □ Gallbladder disease
- □ GERD
- □ Heart Attack
- □ Hepatitis C
- □ HIV/AIDS
- □ High Cholesterol
- □ High Blood Pressure
- □ Inflammatory bowel disease
- □ Migraine headaches
- □ MRSA
- □ Kidney Disease
- □ Liver Disease
- □ Pacemaker
- □ Peptic ulcer disease
- □ Pneumonia
- □ Sleep Apnea
- □ Stroke
- □ Seizure disorders
- □ Thyroid Problems
- □ Tuberculosis
- □ Valvular Heart Disease
- □ ________________________
- □ ________________________
- □ **NO PAST DIAGNOSIS**

PAST SURGERIES / HOSPITALIZATIONS (If none- write 'None')

Type of Surgery/Hospitalization	Year

FAMILY HISTORY: Check (√) if any conditions apply to your immediate family

	Alive and healthy	Cancer (type)	Other	Other	Other
Mother					
Father					
Grandparent ________________					
Sibling ____________________					

Search: *Medical History

HEALTH MAINTENANCE

Have you ever used tobacco? Yes No
Are you currently still using tobacco? Yes No
Age started using tobacco? _____ Age you quit? _______
What type? ▪Cigarettes ▪Cigars ▪Chewing tobacco

If you are over 50, have you had a colonoscopy? Yes No N/A When? ___________________

SYMPTOMS: **Check (√) symptoms you CURRENTLY have**

1. GENERAL	**GASTROINTESTINAL**	**CARDIOVASCULAR**	**SKIN**
□ Chills	□ Poor appetite	□ Chest pain/tightness/pressure	□ Bruise easily
□ Fever or Sweats	□ Constipation	□ Irregular heart beat	□ Rash or hives
□ Loss of weight	□ Change in stool color	□ Poor circulation	□ Non-healing wound/sore
□ NONE OF THE ABOVE	□ Diarrhea	□ Rapid heart beat	□ NONE OF THE ABOVE
2. NEUROLOGIC	□ Hemorrhoids	□ Swelling of ankles	**MEN ONLY**
□ Dizziness	□ Indigestion/heartburn	□ Varicose veins	□ Breast lump
□ Fainting	□ Nausea or vomiting	□ NONE OF THE ABOVE	□ Lump in testicles
□ Headache	□ Rectal bleeding	**EENT**	□ NONE OF THE ABOVE
□ Loss of sleep	□ Stomach Pain	□ Difficulty swallowing	**WOMEN ONLY**
□ NONE OF THE ABOVE	□ Yellowing of skin / eyes	□ Hoarseness	□ Abnormal pap smear
3. MUSCULOSKELETAL	□ NONE OF THE ABOVE	□ Nosebleeds	□ Breast lump
□ Pain: Location __________	**ENDOCRINE**	□ Sinus problems	□ Extreme menstrual pain
□ Weakness: Location: ______	□ Heat/Cold intolerance	□ Vision changes	□ Hot flashes
□ Numbness: Location: ______	□ Excessive thirst	□ Headaches	□ Nipple discharge
□ Swelling: Location:_______	□ Lymph node enlargement	□ NONE OF THE ABOVE	□ NONE OF THE ABOVE
□ NONE OF THE ABOVE	□ NONE OF THE ABOVE	**OTHERS**: Please list your symptoms:	
GENITOURINARY	**RESPIRATORY**		
□ Blood in Urine	□ Persistent cough		
□ Frequent Urination	□ Shortness of breath		
□ Painful Urination	□ Coughing up blood		
□ NONE OF THE ABOVE	□ NONE OF THE ABOVE		

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in my health.

_______________________________________ _______________________
Signature of Patient, Parent, Guardian Date

_______________________________________ _______________________

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Print name of Patient, Parent, Guardian | Date

Reviewed by (nurse, PA, MD) | Date

Office use / orders to-be-scheduled:

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