Patient Medical History Form

Patient Name: _____ DOB: _____ Visit Date:_____

Constitutional

Good General Health	O Yes	O No
Extreme Fatigue:	O Yes	O No
Recent Weight Loss:	O Yes	O No
Night Sweats:	O Yes	O No
Fever:	O Yes	O No

Respiratory

Shortness of Breath:	O Yes	O No
Cough:	O Yes	O No
Snoring:	O Yes	O No
Spitting Blood:	O Yes	O No

Eyes

Change in Vision:	O Yes	O No
Eye Injury:	O Yes	O No

Ear,Nose and Throat

Dentures:	O Yes	O No
Decrease in Hearing:	O Yes	O No
Earache / Drainage	O Yes	O No
Frequent Nose Bleeds:	O Yes	O No
Sinus Drainage/Congestion:	O Yes	O No
Sore Throat/ Hoarseness:	O Yes	O No

Musculoskeletal

Joint Pain/ Stiffness:	O Yes	O No
Joint Swelling:	O Yes	O No
Back Pain/ Stiffness:	O Yes	O No
Muscle Pain / Cramps	O Yes	O No

Gastrointestinal

Change in Appetite:	O Yes	O No
Difficulty Swallowing:	O Yes	O No
Heartburn/Reflux:	O Yes	O No
Fullness:	O Yes	O No
Abdominal Pain:	O Yes	O No
Nausea/Vomiting:	O Yes	O No
Diarrhea:	O Yes	O No
Constipation:	O Yes	O No
Black or Bloody Stools:	O Yes	O No

Endocrine

Heat or Cold Intolerance:	O Yes	O No
Excessive Thirst:	O Yes	O No
Excessive Urination:	O Yes	O No

Cardiac/ Peripheral Vascular Disease

Chest pain:	O Yes	O No
Palpitations:	O Yes	O No
Swelling of Legs, Ankles and Feet:	O Yes	O No
Cramping in Legs w/walking	O Yes	O No

Skin

Moles or Lesions	O Yes	O No
Tattoos	O Yes	O No
Rashes:	O Yes	O No
Easy Bruising:	O Yes	O No
Yellowing (jaundice):	O Yes	O No

Hematology

Slow to Heal after Cuts:	O Yes	O No			
Enlarged Glands:	O Yes	O No			

Breast

Breast Tenderness:	O Yes	O No
Breast Lesions:	O Yes	O No
Breast Discharge:	O Yes	O No

Reproductive/Urinary

Burning w/ Urination:	O Yes	O No
Blood in urine:	O Yes	O No
Frequent Urination:	O Yes	O No
Low Urine Stream/Urgency	O Yes	O No
Lack of Bladder Control	O Yes	O No
Sexual Problems	O Yes	O No
Genital Lesions/Discharge	O Yes	O No

Neurologic

Frequent Headaches:	O Yes	O No
Numbness / Tingling:	O Yes	O No
Seizures:	O Yes	O No
Memory Loss/ Confusion:	O Yes	O No
Unsteady Gait:	O Yes	O No
Tremor:	O Yes	O No
One Sided Weakness	O Yes	O No
Fainting Spells / Dizziness	O Yes	O No

Psychiatric

Anxiety:	O Yes	O No
Depression:	O Yes	O No
Insomnia:	O Yes	O No

Family History **Mark only those that apply or NONE**

Mother O Living O Deceased

O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Father O Living O Deceased

O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Grand-parents O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Siblings O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Children O NONE O Heart Attack O Heart Disease O Peripheral Vascular Disease

O Hypertension O High Cholesterol O Diabetes Mellitus O Stroke O Cancer

Past Medical History (Mark only those that apply or NONE)

NONE O

Cataract:	O	Yes	Diverticulitis:	O	Yes
Glaucoma:	O	Yes	Pancreatitis:	O	Yes
Contact lenses/ Glasses:	O	Yes	Crohns/ Ulcerative colitis	O	Yes
Psoriasis:	O	Yes	Slow Transit Intestine	O	Yes
Chronic Dermatitis:	O	Yes	Prostate Disease	O	Yes
Obesity:	O	Yes	Kidney Stone	O	Yes
Thyroid Disorder:	O	Yes	UTI	O	Yes
Diabetes:	O	Yes	STD	O	Yes
COPD / Chronic Bronchitis:	O	Yes	Sexual Problems	O	Yes
Asthma:	O	Yes	Arthritis / DJD	O	Yes
Sleep Apnea:	O	Yes	Filoromyalgia	O	Yes
Tuberculosis:	O	Yes	Osteoporosis	O	Yes
Chronic Sinusitis:	O	Yes	Gout	O	Yes
Pneumonia:	O	Yes	Rheumatoid	O	Yes
Heart Disease/ Attack:	O	Yes	Lupus	O	Yes
Congestive Heart Failure:	O	Yes	Stroke	O	Yes
Heart Murmur	O	Yes	Dementia	O	Yes
Mitral Valve Prolapse:	O	Yes	Neuropathy	O	Yes
Rhythm Abnormality:	O	Yes	Seizure Disorder	O	Yes
Carotid Disease:	O	Yes	Anxiety/ Panic Attacks	O	Yes
Hypertension:	O	Yes	Depression	O	Yes
High Cholestrol/ TG:	O	Yes	Bipolar/Schizophrenia	O	Yes
GERD / Hernia:	O	Yes	Coumadin Use	O	Yes
PUD:	O	Yes	Anemia	O	Yes
Irritable Bowel Disease:	O	Yes	Bleeding Problems	O	Yes
Hepatitis:	O	Yes	Cancer Type _____	O	Yes

Surgical History **NONE** O (Please mark NONE if nothing below applies)

Tonsillectomy:	O Yes Year: _____	EGD:	O Yes Year:_____
Sinus Surgery:	O Yes Year: _____	Colonoscopy:	O Yes Year:_____
Cardiac Stent:	O Yes Year: _____	Cholecystectomy:	O Yes Year:_____
Vascular Stent:	O Yes Year: _____	Appendectomy:	O Yes Year:_____
CABG:	O Yes Year: _____	Colectomy:	O Yes Year:_____
Pacemaker/ Defibrillator	O Yes Year: _____	Obesity Surgery:	O Yes Year:_____
Aneurysm Surgery	O Yes Year: _____	Lithotripsy:	O Yes Year:_____
Type: _____		Hysterectomy:	O Yes Year:_____
Carotid Surgery	O Yes Year: _____	Cancer Surgery:	O Yes Year:_____
Heart Valve Repair:	O Yes Year:_____	Type: _____	
Hip Surgery:	O Yes Year:_____	_____:	O Yes Year:_____
Knee Surgery:	O Yes Year:_____	_____:	O Yes Year:_____
Other Joint Surgery:	O Yes Year:_____	_____:	O Yes Year:_____

Social History

Marital status: O Married O Single O Divorced O Widowed O Life Partner

Occupation: O Full Time O Part Time O Retired O Homemaker
O Student O Unemployed O Disabled

Smoke : O Yes O No O Trying to Quit O Previous smoker

Smokeless Tobacco: O Yes O No O Trying to Quit O Previously

Alcohol: O Never O Daily O Social Drinker O Trying to Quit O Recovering Alcoholic

Illegal Drugs: O Never O Daily O Recovering Addict O Trying to Quit

HIV infected: O Yes O No O Unknown (never been tested)

Who Lives with you: O Spouse O Children O Partner O Mother O Father O No one

OB/GYN

None O

Pregnancies: O None O 1 O 2 O 3 O 4 O 4+

Miscarriages: O None O 1 O 2 O 3 O 4 O 4+

Menopause: O Yes O No

List all Prescription Medications with Doses:

Medication	Dose	Medication	Dose

Over the Counter Medications:

Diet Pills & Herbal Medications: ____Yes_____NO

Allergies to Medications: _____Yes _____ NO If YES, Please list

Latex Allergies: _____ Yes____ NO

List all current Doctors:

Patient Medical History Form

Patient Name: test Test 2 DOB:01/01/1988 Visit Date:

Correct Way

Fill in the circle completely as demonstrated below

Good General Health	● Yes	O No
Extreme Fatigue:	O Yes	● No
Recent Weight Loss:	● Yes	O No
Night Sweats:	O Yes	● No
Fever:	O Yes	● No

Wrong Ways

Difficulty Swallowing:	● Yes	● No
Heartburn/Reflux:	⊖ Yes	O No
Fullness:	O Yes	⊖ No
Abdominal Pain:	⊠ Yes	O No
Nausea/Vomiting:	O✕ Yes	O No
Diarrhea:	O Yes	✕O No

Past Medical History (Mark only those that apply or NONE) (If one has Glasses and Hypertension)

NONE O

Cataract:	O Yes	GERD / Hernia:	O Yes
Glaucoma:	O Yes	PUD:	O Yes
Contact lenses/ Glasses:	● Yes	Neuropathy	O Yes
Carotid Disease:	O Yes	Seizure Disorder	O Yes
Hypertension:	● Yes	Anxiety/ Panic Attacks	O Yes
High Cholestrol/ TG:	O Yes	Depression	O Yes

Past Medical History (Mark only those that apply or NONE) (If none apply to you)

NONE ●

Cataract:	O Yes	GERD / Hernia:	O Yes
Glaucoma:	O Yes	PUD:	O Yes
Contact lenses/ Glasses:	O Yes	Neuropathy	O Yes
Carotid Disease:	O Yes	Seizure Disorder	O Yes
Hypertension:	O Yes	Anxiety/ Panic Attacks	O Yes
High Cholestrol/ TG:	O Yes	Depression	O Yes