

## Medical History

### General Information

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex:  M  F Date (today): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
 Language(s) spoken:  English  Spanish  Polish  Other: \_\_\_\_\_

### Medical History Check all current and past problems.

- |                      |                             |                       |                                    |
|----------------------|-----------------------------|-----------------------|------------------------------------|
| Allergies/hay fever  | Dental/oral disease         | Hemorrhoids           | Pneumonia                          |
| Anemia               | Diabetes                    | Hepatitis             | Prostate disorder                  |
| Anxiety problem      | Depression                  | Hernia                | Sexual problems                    |
| Arthritis            | Ear/hearing problems        | Herpes                | Sexually transmitted disease       |
| Asthma/wheezing      | Eating disorder             | High blood pressure   | Skin disease/sores                 |
| Back pain            | Eye/vision problems         | High cholesterol      | Sleep problems                     |
| Bleeding disorder    | Foot problems               | HIV/AIDS              | Stomach/digestive disease          |
| Blood transfusion    | Gall bladder disease/stones | Kidney disease/stones | Stroke                             |
| Bone/joint injuries  | Gastritis/ulcer             | Liver disease         | Thyroid disease                    |
| Cancer               | Gout                        | Lung disease          | Tuberculosis (or positive TB test) |
| Chicken pox          | Headaches/migraine          | Menstrual problems    | Urinary problem                    |
| Convulsions/seizures | Heart disease               | Mental illness        |                                    |
| Dementia/memory loss | Heart rhythm problem        | Osteoporosis          |                                    |
|                      |                             | Overweight/obesity    |                                    |

Please give details of any items checked, or add information about other problems if they are not listed:

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### Surgical History List the date and type of any past surgeries.

Date	Surgery	Date	Surgery

**Medications** List your medications, prescription or non-prescription, including the dose and how often you take them. Please include all types of medicine, including pills, injections, creams and eye drops.

Medication	Dose and Frequency	Medication	Dose and Frequency

Are you taking or using anything else for your health or to treat symptoms (such as vitamins, herbs or weight loss products)?

If so, please list them: \_\_\_\_\_

**Allergies and Reactions**

List any substances that have caused a bad reaction, and write the reaction.  
Please include prescription or non-prescription medicines, foods, plants or other materials.

Substance	Reaction	Substance	Reaction

**Personal History and Habits** Your answers will be kept confidential.

**General**

Are you employed? Yes No If yes, what occupation?: \_\_\_\_\_  
 Are you? Single Married Divorced Widowed  
 Are you sexually active? Yes No  
 Do you have children? Yes No If so, how old are they? \_\_\_\_\_  
 Who lives with you in your home? \_\_\_\_\_  
 At home, do you need help getting around, dressing, bathing, using the bathroom, or eating? Yes No  
 If yes, what do you need help with? \_\_\_\_\_  
 Do you exercise? Yes No If yes, what activities and how often? \_\_\_\_\_  
 When was your last dental exam? \_\_\_\_\_ Do you wear dentures? Yes No  
 When was your last vision exam? \_\_\_\_\_ Do you wear glasses or contact lenses? Yes No  
 Have you recently or do you often travel outside the U.S.? Yes No If so, where? \_\_\_\_\_

**Substances**

Do you use tobacco? Yes No  
 If no, have you ever used tobacco? Yes No  
 If yes, what type: Cigarettes How much and for how long: \_\_\_\_\_  
                           Cigars How much and for how long: \_\_\_\_\_  
                           Chewing tobacco How much and for how long: \_\_\_\_\_  
 In the past year, have you ever drunk or used drugs more than you meant to? Yes No  
 In the past year, have you ever thought you should cut down on your drinking or drug use? Yes No  
 Do you ever get annoyed or angry when people talk to you about your drinking/drug use? Yes No  
 Do you ever feel guilty about your drinking/drug use? Yes No  
 Have you ever had an “eye-opener” (morning drink) to get started first thing in the morning? Yes No  
 How many alcohol-containing drinks do you have in a typical week? (one drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor)  
0 1-7 8-10 11-13 14-20 21-30 31-40 41 or more

**Safety**

Have you had any falls within the past 6 months? Yes No  
 Do you use a cane, walker or other device to help you get around? Yes No  
 Do you feel unsafe or threatened in any way (at home, work or otherwise)? Yes No  
 Have you ever been the victim of violence or abuse (including sexual abuse)? Yes No  
 Have you been hit, kicked or otherwise hurt by someone in the past year? Yes No  
 Do you feel unsafe in your current relationship? Yes No  
 Have you been forced to have sex? Yes No  
 Do you or other family members keep gun(s) in the home? Yes No  
 Do you wear a seatbelt when you drive? No Yes Sometimes  
 Do you have smoke detector(s) in your home? No Yes Don't know

**Nutrition**

What is your usual weight? \_\_\_\_\_ What is your usual height? \_\_\_\_\_  
 Have you had decreased food intake for more than one week? Yes No  
 Have you unintentionally gained or lost 10 pounds in the last month? Yes No  
 Do you have difficulty swallowing? Yes No  
 Are you on a modified or special diet, or on tube feeding? Yes No  
 (For **women**): Are you pregnant or breast-feeding? Yes No

**Family History**

Please write which family member(s) have or had the following:

Condition	Family Member(s)	Condition	Family Member(s)
Alcohol / substance abuse		High cholesterol	
Cancer, type: _____		Psychiatric illness	
Diabetes		Stroke	
Heart disease/attack		Tuberculosis	
High blood pressure		Other: _____	

**Obstetric/Gynecologic History** (for women only)

Age of first period? \_\_\_\_\_ If you no longer have periods, at what age did they stop? \_\_\_\_\_  
 Please list: Total # of pregnancies? \_\_\_\_\_ Abortions? \_\_\_\_\_ Miscarriages? \_\_\_\_\_  
 Do you plan to get pregnant within the next year? Yes No  
 Are you using any birth control? Yes No If yes, what type? \_\_\_\_\_

**Cancer Screening**

**Breast Cancer** (for women only):

When was your last mammogram (year)? \_\_\_\_\_ Don't remember Never had one  
 Have you ever had an abnormal mammogram? Yes No Don't know

**Cervical Cancer** (for women only):

When was your last Pap smear (year)? \_\_\_\_\_ Don't remember Never had one  
 Have you ever had an abnormal Pap smear? Yes No Don't know

**Colon cancer** (for men and women over age 50):

Have you ever had a test to see if you had colon cancer? Yes No Don't know

**Prostate cancer** (for men only)

Have you ever had a rectal examination or a "PSA" blood test? Yes No Don't know

**Immunizations** Have you ever had the following vaccines?:

Tetanus: Yes, Year (most recent): \_\_\_\_\_ Never Don't know  
 Flu: Yes, Year (most recent): \_\_\_\_\_ Never Don't know  
 Pneumonia: Yes, Year (most recent): \_\_\_\_\_ Never Don't know

**Advance Directives**

Do you have a Living Will (instructions about the medical care you want given if you get very sick)? Yes No Don't know

Do you have a Power of Attorney for health care (instructions about who you want to make medical decisions for you if you are not able to make them)? Yes No Don't know

Would you like more information about a Living Will or a Power of Attorney? Yes No

**SYMPTOMS – Review of Systems:**

*Please check all that apply to you*

**CONSTITUTIONAL:**

- Fever
- Night sweats
- Weight gain lbs \_\_\_\_\_
- Weight loss lbs \_\_\_\_\_
- Exercise intolerance

**EYES:**

- Dry eyes
- Irritation
- Vision change

**EARS, NOSE MOUTH, THROAT:**

- Difficulty hearing
- Ear pain
- Frequent nosebleeds
- Nose/sinus problems
- Sore throat
- Bleeding gums
- Snoring
- Dry mouth
- Oral abnormalities
- Mouth ulcer
- Teeth abnormalities

**CARDIOVASCULAR:**

- Chest pain on exertion
- Arm pain on exertion
- Shortness of breath when walking
- Shortness of breath when lying down
- Palpitations
- Known heart murmur
- Light-headed on standing

**RESPIRATORY:**

- Cough
- Wheezing
- Shortness of breath
- Coughing up blood
- Sleep apnea

**GASTROINTESTINAL:**

- Abdominal pain
- Heartburn
- Vomiting
- Change in appetite
- Black or tarry stools
- Diarrhea
- Constipation
- Vomiting blood

**GENITOURINARY:**

- Urinary loss
- Difficulty urinating
- Increased urinary frequency
- Blood in urine (hematuria)
- Incomplete emptying

**URINARY FEMALE:**

- Abnormal vaginal discharge
- Bleeding between periods
- Breast lump
- Hot flashes
- Irregular periods
- Painful intercourse
- Severe menstrual pain
- Sore(s) on genitals

**URINARY MALE:**

- Lump in testicle
- Penis discharge
- Sore(s) on genitals
- Inadequacy of penile erection

**MUSCULOSKELETAL:**

- Muscle aches
- Muscle weakness
- Joint pain
- Back pain
- Edema

**INTEGUMENTARY/SKIN:**

- Abnormal mole
- Jaundice
- Rash
- Nail problem
- Itching
- Dry skin
- Growths/lesions

**NEUROLOGIC:**

- Loss of consciousness
- Weakness
- Numbness
- Memory/Loss
- Seizures
- Dizziness
- Headaches
- Migraine
- Restless legs

**PSYCHIATRIC:**

- Depression
- Anxiety
- Sleep disturbances/restless sleep
- Feel unsafe in a relationship
- Alcohol overuse

**ENDOCRINE:**

- Fatigue
- Increased thirst
- Hair loss
- Increased hair growth
- Cold intolerance

**HEMATOLOGIC/LYMPHATIC:**

- Swollen glands
- Easy bruising
- Excessive bleeding

**ALLERGIC/IMMUNOLOGIC:**

- Runny nose
- Sinus pressure
- Itching
- Hives
- Frequent sneezing

Reviewed by:

\_\_\_\_\_  
PHYSICIAN

\_\_\_\_\_  
DATE