Print Form

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Medical Clinic

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PATIENT MEDICAL HISTORY

Name:	DOB:	☐ Male ☐ Female	Date:

Please check conditions, which you have had in the past:

Cardiovascular System
- ☐ Rheumatic Fever
- ☐ High Cholesterol
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Frequent Chest Pain
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

Lymphatic / Hematologic
- ☐ Diabetes Mellitus
- ☐ Overactive Thyroid
- ☐ Underactive Thyroid
- ☐ Anemia
- ☐ Thyroid Goiter
- ☐ Blood Transfusion

Skin / Breast
- ☐ Acne
- ☐ Eczema / Psoriasis
- ☐ Fibrocystic Breast Disease
- ☐ Abnormal Mammogram
- ☐ Rashes
- ☐ Hives
- ☐ Moles

Respiratory
- ☐ Sleep Apnea
- ☐ Frequent Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Asthma
- ☐ Clots in Lungs
- ☐ Tuberculosis

Musculoskeletal / Extremities
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Joint Pain
- ☐ Gout
- ☐ Broken Bones
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Fibromyalgia
- ☐ Neck Pain (hern. disc)
- ☐ Back Pain (herniated disc)

Head/Eyes/Ears/Nose/Throat
- ☐ Glasses / Contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss
- ☐ Frequent Ear Infections
- ☐ Ringing in Ears
- ☐ Allergies
- ☐ Frequent Sinus Infections
- ☐ Mouth Sores

Neurologic / Psychiatric
- ☐ Seizure
- ☐ TIA
- ☐ Stroke
- ☐ Numbness
- ☐ Weakness
- ☐ Memory Loss
- ☐ Migraine Headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Suicide Attempt
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Mental Illness
- ☐ Dizziness
- ☐ Vertigo
- ☐ Peripheral Nerve Disease
- ☐ Insomnia

General
- ☐ Abnormal Weight Loss
- ☐ Abnormal Weight Gain
- ☐ Cancer/Tumor:

_____

_____ # of Pregnancies
_____ Live Births
_____ Miscarriages
_____ Abortions

GI /GU
- ☐ Heartburn
- ☐ Stomach Ulcers
- ☐ Gallstones
- ☐ Blood in Stool
- ☐ Hepatitis
- ☐ Diarrhea / Constipation
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Colon Polyps
- ☐ Urinary Frequency
- ☐ Bladder Infections
- ☐ Prostate Disease
- ☐ Urinary Incontinence
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Diverticulitis/Diverticulosis
- ☐ Irritable Bowel Disease
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Endometriosis
- ☐ Abnormal PAP
- ☐ Sex Transmitted Infection
- ☐ HIV Infection

Provider Notes:

Please list any allergies or intolerance to drugs or other substances:

Please list the medications currently taken, their dosage and how many times per day you take them:

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Please indicate any surgeries you have had and the year you had them:

- ☐ Angioplasty _____
- ☐ Carotid Artery _____
- ☐ Other Vascular _____
- ☐ Coronary Bypass _____
- ☐ Chest/Lung _____
- ☐ Tonsillectomy _____
- ☐ Neurosurgery _____
- ☐ Trauma Related _____
- ☐ Back/neck _____
- ☐ Hip _____
- ☐ Knee _____
- ☐ Carpal Tunnel _____
- ☐ Sinus _____
- ☐ Ear_____
- ☐ Stomach _____
- ☐ Inguinal Hernia _____
- ☐ Colonoscopy _____
- ☐ Gallbladder _____
- ☐ Appendectomy _____
- ☐ Prostate _____
- ☐ Bladder _____
- ☐ Tubal Ligation _____
- ☐ C-Section _____
- ☐ Hysterectomy _____
- ☐ Ovary Removed _____
- ☐ Breast _____
- ☐ Thyroid _____
- ☐ Other _____

Provider Notes: _____

Please indicate when you last had any of the following preventative tests or services:

- ☐ Cardiac Angiogram _____
- ☐ Stress Test _____
- ☐ EKG _____
- ☐ Chest X-Ray _____
- ☐ Echocardiogram _____
- ☐ Flu Vaccine _____
- ☐ Pneumonia Vaccine _____
- ☐ Tetanus Vaccine _____
- ☐ Hepatitis Vaccine _____
- ☐ Bone Density Test _____
- ☐ PSA Blood Test _____
- ☐ Rectal Exam _____
- ☐ Colon Cancer Stool Test _____
- ☐ Flexible Sigmoidoscopy _____
- ☐ Barium Enema _____
- ☐ Colonoscopy _____
- ☐ Mammo/Breast Exam_____
- ☐ PAP Smear _____

Last Menstrual Period:_____

Provider Notes: _____

Family Medical History

Please check major illness in your family members (mother, father, brother, sister, or children)

- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Hemophilia
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Neurologic Disorder
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer

Provider Notes: _____

Personal Information

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What is or was your occupation: _____

Who is currently living in your home: _____

Have you ever felt threatened or do you currently feel threatened (emotionally/physically) in your home? ☐ Yes ☐ No

Risk Reduction:

Are you sexually active? ☐ Yes ☐ No

Do you or your partner use condoms (practice safe sex)? ☐ Always ☐ Never ☐ Sometimes

Do you use tobacco products? ☐ No ☐ Yes / how much: _____

Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc.)? _____

How much alcohol in terms of bottles/cans do you consume weekly? ☐ 0-5 ☐ 6-12 ☐ greater than 12

Do you perform the following and if yes, how often? ☐ Self Breast Exam _____ ☐ Self Testicular Exam _____

Signature of Patient/Legal Representative		
_____	_____	_____
Signature	Date	Relationship to the Patient