

**REPORT OF MEDICAL HISTORY** Name \_\_\_\_\_

Date \_\_\_\_\_

ID # \_\_\_\_\_ DOB \_\_\_\_\_

PCP \_\_\_\_\_ MRN \_\_\_\_\_

**I. PAST MEDICAL HISTORY:**

Have you ever been diagnosed or treated by a health care provider for any of the following conditions? (Please give approximate date)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal mammogram           | <input type="checkbox"/> Ear/nose/throat trouble | <input type="checkbox"/> Kidney problem                            |
| <input type="checkbox"/> Abnormal PAP smear           | <input type="checkbox"/> Eating disorder         | <input type="checkbox"/> Learning disabilities                     |
| <input type="checkbox"/> Alcohol/other substance use  | <input type="checkbox"/> Eye problems            | <input type="checkbox"/> Measles/Mumps/Rubella (German Measles)    |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Mental health condition-type _____        |
| <input type="checkbox"/> Arthritis/joint disease      | <input type="checkbox"/> Hay fever               | <input type="checkbox"/> Mole removal                              |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Head injury             | <input type="checkbox"/> Mononucleosis                             |
| <input type="checkbox"/> Back problems                | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Neck injury                               |
| <input type="checkbox"/> Bleeding trait               | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Seizures                                  |
| <input type="checkbox"/> Broken bones                 | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Sexually transmitted disease-type _____   |
| <input type="checkbox"/> Cancer-type _____            | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Sinusitis                                 |
| <input type="checkbox"/> Chicken pox                  | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Skin diseases                             |
| <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Thyroid problem                           |
| <input type="checkbox"/> Congenital defect            | <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Tuberculosis (TB) / Positive TB skin test |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Ulcer / stomach or digestive problems     |
| <input type="checkbox"/> Dizziness or fainting spells | <input type="checkbox"/> Joint injuries          | <input type="checkbox"/> Other _____                               |

PAST SURGICAL HISTORY: (type/date) \_\_\_\_\_

**II. FAMILY HISTORY:** Were you adopted? No \_\_\_\_\_ Yes \_\_\_\_\_

Please note the ages at which any of these close relatives have been diagnosed with the following:

	Father	Mother	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____
Heart disease/Attack	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____	_____

**III. ALLERGIES:** List any allergies you have to medication and/or food: \_\_\_\_\_

**IV. MEDICATIONS:**

List present medication you are taking (including over-the-counter medications, vitamins, herbs, and supplements):

NAME	STRENGTH	HOW OFTEN?	FOR WHAT CONDITION?
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**V. REVIEW OF SYSTEMS:** Please check any symptoms you have had recently or in the past year.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Frequent headaches               | <input type="checkbox"/> Wheezing                    | <input type="checkbox"/> Heartburn or indigestion |
| <input type="checkbox"/> Change in vision                 | <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> Swallowing difficulty    |
| <input type="checkbox"/> Eye problem                      | <input type="checkbox"/> Shortness of breath         | <input type="checkbox"/> Nausea or vomiting       |
| <input type="checkbox"/> Eye exam – date _____            | <input type="checkbox"/> Palpitations                | <input type="checkbox"/> Abdominal pain           |
| <input type="checkbox"/> Recent hearing change            | <input type="checkbox"/> Frequent cough              | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Ringing in ears                  | <input type="checkbox"/> Night sweats                | <input type="checkbox"/> Change in stools         |
| <input type="checkbox"/> Dizziness, fainting or blackouts | <input type="checkbox"/> Ankle swelling              | <input type="checkbox"/> Blood in stool           |
| <input type="checkbox"/> Ear infection or discharge       | <input type="checkbox"/> History of rheumatic fever  | <input type="checkbox"/> Constipation             |
| <input type="checkbox"/> Mouth sores                      | <input type="checkbox"/> Frequent urination          | <input type="checkbox"/> Weight loss or gain      |
| <input type="checkbox"/> Dental exam – date _____         | <input type="checkbox"/> Blood in urine              | <input type="checkbox"/> Seizures or convulsions  |
| <input type="checkbox"/> Mouth pain                       | <input type="checkbox"/> Burning/pain with urination | <input type="checkbox"/> Numbness or tingling     |
| <input type="checkbox"/> Frequent nasal discharge         | <input type="checkbox"/> Hair loss                   | <input type="checkbox"/> Muscle pain or weakness  |
| <input type="checkbox"/> Nasal Bleeding                   | <input type="checkbox"/> Rash                        | <input type="checkbox"/> Back problems            |
| <input type="checkbox"/> Recurrent nasal congestion       | <input type="checkbox"/> Moles (unusual / changing)  | <input type="checkbox"/> Joint problems           |
| <input type="checkbox"/> Sore throat                      | <input type="checkbox"/> Breast lump                 | <input type="checkbox"/> Loss of consciousness    |
| <input type="checkbox"/> Sinus infections                 | <input type="checkbox"/> Swollen glands              |   |
| <input type="checkbox"/> Tattoo or body piercing          | <input type="checkbox"/> Blood transfusion           |   |

V. REVIEW OF SYSTEMS (Continued):

FOR MEN ONLY:

- \_\_\_\_\_ Drip, discharge or burning from penis
- \_\_\_\_\_ Lumps or swelling of testicles
- \_\_\_\_\_ Difficulty with erection

FOR WOMEN ONLY:

- \_\_\_\_\_ Unusual vaginal discharge, itching, or burning
- \_\_\_\_\_ Change in menstrual periods
- \_\_\_\_\_ Bleeding between periods
- \_\_\_\_\_ Severe cramps
- Date of last PAP smear \_\_\_\_\_
- Date of last menstrual period \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_

FOR BOTH MEN AND WOMEN: (Answering these questions is optional, however, information provided will allow your provider to more closely meet your health care needs.)

	No	Yes		No	Yes
1. Felt exhausted or fatigued most of the time?	_____	_____	18. Are there guns in your residence?	_____	_____
2. Felt "blue", lonely or depressed?	_____	_____	If yes, are they locked up?	_____	_____
3. Been more irritable than usual?	_____	_____	19. Do you drink caffeinated coffee, tea, soda?	_____	_____
4. Had frequent crying spells, or felt like crying?	_____	_____	How much per day? _____		
5. Had difficulty trying to calm down or relax?	_____	_____	20. Do you smoke or use tobacco now?	_____	_____
6. Been overly anxious or been worrying a lot?	_____	_____	If you have stopped, when was it? _____		
7. Felt that you or others would be better off dead?	_____	_____	21. Average number of alcoholic drinks per week	_____	
8. Desired or sought counseling?	_____	_____	22. Have you ever felt you should cut down on your drinking?	_____	_____
9. Are you generally unsatisfied with school/work?	_____	_____	23. Have you ever been annoyed with people criticizing your drinking?	_____	_____
10. Do you have trouble finding someone to discuss your personal problems?	_____	_____	24. Ever felt bad or guilty about your drinking?	_____	_____
11. Are you sexually active now?	_____	_____	25. Do you drink alcohol to settle your nerves in the morning?	_____	_____
12. Are there sexual concerns you would like to discuss?	_____	_____	26. What kinds of exercise do you do?	_____	
13. Do you use or have contact with anyone using intravenous drugs?	_____	_____	How often? _____		
14. Do you use street (recreational) drugs?	_____	_____	27. Do you use a seat belt when in a car?	_____	_____
15. Would you like to be tested for HIV disease?	_____	_____	28. Do you use sunscreen routinely?	_____	_____
16. What do you do for family planning or birth control? _____			29. Are there smoke detectors in your residence?	_____	_____
17. In the last five years how many sexual partners have you had? _____			30. What are your hobbies or leisure activities? _____		
			31. In what kind of groups or organizations do you participate? _____		

Would you like patient education on any topic?   No \_\_\_\_\_ Yes \_\_\_\_\_  
 If yes, what topics? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any other health concerns?       No \_\_\_\_\_ Yes \_\_\_\_\_  
 If yes, what are your concerns? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 (Signature of person completing form)

\_\_\_\_\_  
 (Date)