

# MEDICAL HISTORY FORM

By choosing to have this assessment of your health, it is assumed that you take your health seriously. Therefore, PLEASE complete this form to the best of your knowledge. For first health assessment, fill out both sides. For repeat health assessment, fill out back only.

Name	Date of Birth / /	Place of Birth	Occupation	Primary Care Physician
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Date of Visit	Highest Level of School	Race	Religious Preference	Organ Donor?	Who Referred You?
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Medical History: List serious illnesses, injuries, operations, and other hospitalizations and indicate year these occurred.

PROBLEM	YEAR	PROBLEM	YEAR

LIST MEDICINES YOU TAKE NOW (INCLUDING VITAMINS, BIRTH CONTROL PILLS, OVER-THE-COUNTER DRUGS)

MEDICINE AND DOSE (IF KNOWN)	MEDICINE AND DOSE (IF KNOWN)

	YES	NO		YES	NO
HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICINE? WHICH? DESCRIBE REACTION:			DO YOU KNOW OF ANY CONDITION FOR WHICH YOU BELIEVE YOU NOW NEED OR WILL NEED TREATMENT? (MEDICINE, SURGERY OR PREGNANCY, ETC.) IF YES, WHAT?		
HAVE YOU HAD AN ALLERGIC REACTION TO INSECT BITES OR STINGS? DESCRIBE:			HAVE YOU BEEN UNDER A PHYSICIAN'S CARE FOR A CHRONIC CONDITION? IF YES, WHY?		
DO YOU HAVE OTHER ALLERGIES: DESCRIBE:			HAVE YOU BEEN REJECTED FOR INSURANCE, MILITARY SERVICE OR EMPLOYMENT FOR A MEDICAL REASON? IF YES, WHY?		
DO YOU SMOKE? IF SO, HOW MANY PACKS PER DAY? DID YOU EVER SMOKE? IF SO, HOW MANY PACKS PER DAY? YRS?			HAVE YOU EVER HAD AN EYE EXAM? IF YES, WHEN WAS THE MOST RECENT?		
DO YOU DRINK ALCOHOL? (INCLUDING BEER) APPROXIMATE QUANTITY PER WEEK? IS THIS A PROBLEM FOR YOU OR YOUR EMPLOYER?			HAVE YOU EVER BEEN EXPOSED TO HAZARDS AT YOUR JOB? WHAT HAZARD?		
DO YOU USE ANY STREET DRUGS? WHAT? HOW OFTEN?			DO YOU USE SEATBELTS REGULARLY?		
HAS A PSYCHIATRIST EVER TREATED YOU? IF YES, WHEN?			DO YOU PRACTICE SAFE SEX? (MONOGAMOUS RELATIONSHIP/CONDOMS) N/A		
DID YOU RECEIVE IN-PATIENT TREATMENT? IF YES, WHEN?			DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES?  IF NOT, ARE YOU INTERESTED IN MORE INFORMATION? WHO LIVES WITH YOU?		
HAVE YOU TRAVELED OUTSIDE THE UNITED STATES WITHIN THE PAST 5 YEARS? WHERE? WHEN?			DO YOU FEEL SAFE AT HOME? DO YOU PARTICIPATE IN REGULAR EXERCISE?  WHAT? HOW OFTEN?		
DO YOU HAVE A PHYSICAL DISABILITY? IF YES, DESCRIBE.			WHAT IS THE EASIEST WAY FOR YOU TO LEARN?  <input type="checkbox"/> READING <input type="checkbox"/> LISTENING <input type="checkbox"/> DEMONSTRATION		
ARE THERE ANY RELIGIOUS AND/OR CULTURAL NEEDS IN LEARNING MEDICAL INFORMATION? IF SO, WHAT ARE THEY?					

FAMILY HISTORY: (ANY FAMILY HISTORY OF HYPERTENSION, HEART DISEASE, CANCER, DIABETES, KIDNEY DISEASE, TUBERCULOSIS, SICKLE CELL ANEMIA, BLEEDING TENDENCY, CRIPPLING ARTHRITIS, ALCOHOLISM, SUICIDE, OTHER)

FATHER	
MOTHER	
MATERNAL GRANDPARENTS	
PATERNAL GRANDPARENTS	
SIBLINGS	

# FAMILY MEDICINE/INTERNAL MEDICINE REVIEW OF SYSTEMS

STATEMENT OF PRESENT HEALTH: (GIVE A DESCRIPTION OF PAST HISTORY, IF COMPLAINT EXISTS):

SYSTEM REVIEW: PLEASE CHECK THE APPROPRIATE BOX: FOR EACH PROBLEM CHECK NEVER, PAST OR NOW. PAST MEANS ANYTIME LONGER THAN SIX MONTHS AGO.

N E P V A N E S O R T W	HAVE YOU EVER HAD:		
<b>GENERAL/CONSTITUTIONAL:</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss or weight gain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged fever/chills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>HEAD/EYES/EARS/NOSE/THROAT:</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses or contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic nasal discharge, drainage or sneezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired hearing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When was your last eye exam?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>NEUROLOGICAL:</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness, seizures, convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>CARDIOVASCULAR</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest/Angina
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal heart rhythm or murmur
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>RESPIRATORY</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath at night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>GASTROINTESTINAL</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits (constipation or diarrhea)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Noted blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids or rectal disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>GENITOURINARY</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination at night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty holding urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty stopping or starting urine stream
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infection
<b>MALE</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or discharge from penis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump on or pain of testicle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Condom use
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sexual function

N E P V A N E S O R T W	HAVE YOU EVER HAD:		
<b>FEMALE</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Method of birth control if sexually active/heterosexual
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid-cycle bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain with intercourse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge or sores
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problem with sexual function
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your periods regular
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been pregnant
<b>MUSCULOSKELETAL</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in joints/arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain or injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>SKIN/BREAST</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change or new growth in mole
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast nipple discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>EMOTIONAL</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have trouble sleeping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you often depressed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you often anxious or nervous
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ever had loss of memory
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>OPTIONAL</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you sexually active
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you sexually active with members of opposite sex <input type="checkbox"/> , same sex <input type="checkbox"/> , or both <input type="checkbox"/> .
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If sexually active with the opposite sex, do either of you use contraception (birth control?) If yes what form?
<b>HEMATOLOGIC/LYMPH</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding or abnormal bruising
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A transfusion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any swelling of lymph nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<b>ENDOCRINE</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold or heat intolerance, any thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
REVIEWED _____ DATE _____			
REVIEWED _____ DATE _____			
REVIEWED _____ DATE _____			

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_