Patient Medical History Form

Patient Name: ________________________________ DOB: _________________

For each section below mark Yes, No or Denies All for symptoms you have had in the last Two Weeks

General	O **Denies All**	
Feeling ill:	O Yes	O No
Recent weight loss:	O Yes	O No
Fatigue:	O Yes	O No
Fever:	O Yes	O No
Eyes	O **Denies All**	
Eye Disease:	O Yes	O No
Wear glasses/contact lenses:	O Yes	O No
Blurred/Double vision:	O Yes	O No
Ears/Nose/Mouth/Throat	O **Denies All**	
Ringing in ears:	O Yes	O No
Hearing loss:	O Yes	O No
Earaches/Drainage:	O Yes	O No
Chronic sinus problems:	O Yes	O No
Nose Bleeds:	O Yes	O No
Mouth sores:	O Yes	O No
Bleeding gums:	O Yes	O No
Bad breath/bad taste:	O Yes	O No
Sore Throat:	O Yes	O No
Swollen glands in neck:	O Yes	O No
Cardiovascular	O **Denies All**	
Chest pain:	O Yes	O No
Palpitations:	O Yes	O No
Shortness of breath while lying flat:	O Yes	O No
Swollen extremities:	O Yes	O No
Respiratory	O **Denies All**	
Shortness of breath at exercise:	O Yes	O No
Shortness of breath at rest:	O Yes	O No
Chronic cough:	O Yes	O No
Spitting up blood:	O Yes	O No
Wheezing:	O Yes	O No
Gastrointestinal	O **Denies All**	
Loss of appetite:	O Yes	O No
Change in bowel habits:	O Yes	O No
Nausea/ Vomiting:	O Yes	O No
Frequent Diarrhea:	O Yes	O No
Constipation:	O Yes	O No
Rectal Bleeding/Blood in stool:	O Yes	O No
Abdominal pain:	O Yes	O No
Heartburn:	O Yes	O No
Trouble swallowing:	O Yes	O No
Genitourinary	O **Denies All**	
Frequent urination:	O Yes	O No
Burning w/ Urination:	O Yes	O No
Blood in urine:	O Yes	O No
Weak urine stream:	O Yes	O No
Trouble w/ control of urination:	O Yes	O No
Kidney Stones:	O Yes	O No
Urgent urination:	O Yes	O No
Sexual difficulties:	O Yes	O No
Men Only:		
Male only-Testicle Pain:	O Yes	O No
Musculoskeletal	O **Denies All**	
Joint Pain:	O Yes	O No
Joint Stiffness/Swelling:	O Yes	O No
Joint/Muscle weakness:	O Yes	O No
Muscle pain/cramps:	O Yes	O No
Back Pain:	O Yes	O No
Cold Extremities:	O Yes	O No
Difficulty walking:	O Yes	O No

Page Over

Skin	O **Denies All**	
Rashes/Itching:	O Yes	O No
Change in skin color:	O Yes	O No
Change in hair/nails:	O Yes	O No
Varicose veins:	O Yes	O No
Neurologic	O **Denies All**	
Chronic Headaches:	O Yes	O No
Dizziness:	O Yes	O No
Tingling/Numbness:	O Yes	O No
Tremors:	O Yes	O No
Paralysis:	O Yes	O No
Head Injury:	O Yes	O No

Psychiatric	O **Denies All**	
Memory loss or confusion:	O Yes	O No
Nervousness:	O Yes	O No
Depression:	O Yes	O No
Insomnia:	O Yes	O No
Endocrine	O **Denies All**	
Glandular/Hormone problems:	O Yes	O No
Extreme Thirst:	O Yes	O No
Cold Intolerance:	O Yes	O No
Heat Intolerance:	O Yes	O No
Hematologic	O **Denies All**	
History of Blood clots:	O Yes	O No
Easy Bruising:	O Yes	O No
Phlebitis:	O Yes	O No

Past Medical History **Please Mark all that apply**

O Diabetes
O High Blood Pressure
O Cancer
O Stroke
O Heart Attack
O Arthritis
O Seizures
O Bleeding tendency/Disorder
O Acute Infections
O Digestive Problems
O High Cholesterol
O GERD/Heartburn
O Gynecological Problems
O Anemia
O Tuberculosis
O COPD/Emphysema
O Ulcer disease
O Liver Problems
O Hepatitis
O Kidney problems
O Prostate problems
O Blood Transfusion
O Thyroid disease
O Congestive Heart Failure
O Asthma
O Angina
O Congenital/Birth defects
O Hemorrhoids
O Diverticulosis
O Pancreatitis
O Ulcerative Colitis
O Coronary Artery Disease
O Venereal Disease
O Atrial Fibrillation
O Sleep Apnea
O TIA's
O Fibromyalgia
O Colon Polyps
O HIV
O Muscle Disorder
O ____________________
O ____________________

Surgical History **Please Mark All that Apply**

O Colonoscopy
O EGD(Upper endoscopy)
O Pacemaker
O Colon Surgery
O Cholecystectomy
O Appendectomy
O Hemorrhoidectomy
O Bypass Surgery
O Hernia Surgery
O Hysterectomy
O Ovaries Removed
O Breast Cancer Surgery
O Prostate Surgery
O Back Surgery
O Hip Surgery
O Knee Surgery
O Weight Loss Surgery
O ________________

Social History **Please Mark All that Apply**

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

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

Exercise: O Never O Daily O 1-2 times per week O 3-4 times per week

Diet: O Yes O No O Physician prescribed Diet

Caffeine use: O None O Daily O Occasionally

If yes: O 1 cup/drink a day O 2-3 cups/drinks a day O 4 or more cups/drinks a day

Tobacco use: O Yes O No O Trying to Quit O Previous smoker

O Cigarettes O Cigars O Smokeless Tobacco O E-Cigarette/Vaping

If yes, trying to quit or previous, mark daily use: O ½ pack O 1 pack O 2 packs O more than 2 packs /day

Number of years: O 0-5 years O 6-10 years O 10-20 years O 20 + years

Alcohol use: O Never O Daily O Social Drinker O Trying to Quit O Previously

If yes: O Less than 12 drinks a month O 1-12 drinks a week O 4-15 drinks a week O more than 2 drinks a day

Recreational Drug use: O Never O Daily, Type: ______________ O Trying to Quit O Previously

Preventative Care

1. Have you had a flu shot? Yes or No If yes, Date Received ________________
2. Have you had a pneumonia vaccine? Yes or No If yes, Date Received _____________

Page Over

Family History **Please Mark All that Apply**

Mother O Alive O Deceased

O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Arthritis
O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma O Anemia O Stroke
O Diabetes O Hypertension O Cancer _____________

Father O Alive O Deceased

O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Arthritis
O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma O Anemia O Stroke
O Diabetes O Hypertension O Cancer _____________

Sibling O Alive O Deceased

O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Arthritis
O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma O Anemia O Stroke
O Diabetes O Hypertension O Cancer _____________

Please list all prescribed drugs and over the counter drug such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

Allergies

Name of Drug or Allergy	Reaction