

MEDICAL HISTORY FORM

(Please Print)

Today's Date: _____

Name (Last Name First)	Date of Birth	Place of Birth	Occupation	Primary Care Physician
	/ /			

Is this a Referral? Y ___ / N ___ If so, by Whom?	Highest Education	Race	Religious Preference	Organ Donor?

MEDICAL HISTORY: List serious illnesses, injuries, operations, and hospitalizations.

Health Problem	Year	Health Problem	Year

MEDICATION: List medications, including vitamins, over-the-counter drugs, and birth control pills that you take currently.

Medication (dosage, if known)	Medication (dosage, if known)	Medication (dosage, if known)

	Yes	No		Yes	No
Are you allergic to any medications? If so, please list below:			Have you traveled outside the United States within the past 5 years? If so, Where? _____ When? _____		
Are you allergic to any insect bites or stings? If so, please list below:			Are you physically handicapped? If yes, list below.		
Are you aware of any allergies? If so, please list below:			Any religious or cultural restrictions to medical treatment? If so, list below.		
Do you smoke? If so, how much? _____ If not now, have you ever smoked? How much? _____			Do you practice safe sex? (Monogamous relationship / condoms) N/A		
Do you drink alcohol (including beer)? If so, how much per week? _____ If not now, did you ever drink? How much? _____			Do you exercise? If so, how often? _____ What type (list below)?		
Do you use illegal substances? If so, list with frequency below.			Have you ever had an eye exam? If so, when?		
Any psychiatric treatment? If so, when? _____ In or Out Patient treatment? _____			Do you use seatbelts? If so, how often?		
Any known conditions for which you need treatment? If so, list below:			Do you have a Living Will or Advance Directives? If not, would you like more information? Y ___ / N ___		
Have you been treated for any chronic condition? If so, list below:			Identify which mode of learning you prefer. Reading ___ Listening ___ Demonstration ___ Other ___		
Have you ever been exposed to hazardous materials? If so, list below: When? _____ Where? _____			Is there any other health-related info that you wish to share? If so, please list below:		

FAMILY HISTORY: For the family members below, list any hypertension, heart disease, cancer, diabetes, kidney disease, tuberculosis, sickle cell anemia, bleeding tendency, crippling arthritis, alcoholism, suicide or other familial conditions.

MOTHER	
FATHER	
MATERNAL GRANDPARENTS	
PATERNAL GRANDPARENTS	
SIBLINGS	

**FAMILY MEDICINE / INTERNAL MEDICINE
SYSTEMS REVIEW**

Check problems appropriately.

N E V E R	P A S S	N O W		N E V E R	P A S S	N O W	
			HAVE YOU EVER HAD:				HAVE YOU EVER HAD:
—	—	—	GENERAL / CONSTITUTIONAL	—	—	—	FEMALE
—	—	—	Unexplained weight loss or weight gain	—	—	—	Method of birth control if sexually active/heterosexual
—	—	—	Excessive fatigue	—	—	—	Mid-cycle bleeding
—	—	—	Prolonged fever / chills	—	—	—	Pain with intercourse
—	—	—	Other	—	—	—	Vaginal discharge or sores
				—	—	—	Painful periods
				—	—	—	Sexually transmitted disease
				—	—	—	Problem with sexual function
				—	—	—	Are your periods regular
				—	—	—	Have you ever been pregnant
—	—	—	HEAD / EYES/ EARS / NOSE / THROAT:	—	—	—	MUSCULOSKELETAL
—	—	—	Frequent or severe headaches	—	—	—	Pain in joints/arthritis
—	—	—	Wear glasses or contact lenses	—	—	—	Chronic back pain or injury
—	—	—	Chronic nasal discharge, drainage or sneezing	—	—	—	Other:
—	—	—	Impaired hearing				
—	—	—	When was your last eye exam?				
—	—	—	Other:				
—	—	—	NEUROLOGICAL:	—	—	—	SKIN / BREAST
—	—	—	Memory loss	—	—	—	Change or new growth in mole
—	—	—	Fainting, dizziness, seizures, convulsions	—	—	—	Breast lump
—	—	—	Other:	—	—	—	Breast nipple discharge
				—	—	—	Other:
—	—	—	CARDIOVASCULAR	—	—	—	EMOTIONAL
—	—	—	Rheumatic Fever	—	—	—	Do you have trouble sleeping
—	—	—	Pain or pressure in chest / Angina	—	—	—	Are you often depressed
—	—	—	Any heart trouble	—	—	—	Are you often anxious or nervous
—	—	—	Palpitation or pounding heart	—	—	—	Ever had loss of memory
—	—	—	Abnormal heart rhythm or murmur	—	—	—	Other:
—	—	—	Swelling of ankles				
—	—	—	High blood pressure				
—	—	—	Other:				
—	—	—	RESPIRATORY	—	—	—	OPTIONAL
—	—	—	Chronic cough	—	—	—	Are you sexually active
—	—	—	Asthma or wheezing	—	—	—	Are you sexually active with members of\
—	—	—	Shortness of breath at night	—	—	—	opposite sex __, same sex __, or both __
—	—	—	Shortness of breath	—	—	—	If sexually active with the opposite sex, do either of you
—	—	—	Other:	—	—	—	use contraception (birth control). If so, what form?
—	—	—	GASTROINTESTINAL	—	—	—	HEMATOLOGICAL / LYMPH
—	—	—	Abdominal pain	—	—	—	Anemia
—	—	—	Loss of appetite	—	—	—	Excessive bleeding or abnormal bruising
—	—	—	Change in bowel habits (constipation or diarrhea)	—	—	—	A transfusion
—	—	—	Noted blood in stool	—	—	—	Any swelling of lymph nodes
—	—	—	Hemorrhoids or rectal disease	—	—	—	Other:
—	—	—	Other				
—	—	—	GENITOURINARY	—	—	—	ENDOCRINE
—	—	—	Frequent urination at night	—	—	—	Cold or heat intolerance, any thyroid problems
—	—	—	Frequent painful urination	—	—	—	Excessive thirst or hunger
—	—	—	Difficulty stopping or starting urine stream	—	—	—	Other:
—	—	—	Urinary tract infection				
—	—	—	MALE	Reviewed _____			Date _____
—	—	—	Sores or discharge from penis	Reviewed _____			Date _____
—	—	—	Lump on or pain of testicle	Reviewed _____			Date _____
—	—	—	Sexually transmitted disease				
—	—	—	Condom use				
—	—	—	Problems with sexual function	Reviewed _____			Date _____

NAME: _____ DOB: _____ DATE: _____