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Medical History Form

Patient Name: ___________________________ **Date of Birth:** _______________ **Marital Status:** _________

Primary Care Physician: ____ **Phone #** ______________

List all other physicians you currently see:

	Name	Specialty	Phone Number
1.	______________________	______________________	______________________
2.	______________________	______________________	______________________
3.	______________________	______________________	______________________
4.	______________________	______________________	______________________
5.	______________________	______________________	______________________
6.	______________________	______________________	______________________
7.	______________________	______________________	______________________

1. **Have you recently had:**

	Yes	No		Yes	No
Loss of Appetite	____	____	Swelling of your abdomen	_____	_____
Weight Loss	____	____	Abdominal cramps or pain	_____	_____
Fever	____	____	Change in bowel habits	_____	_____
Chills	____	____	Change in stool	_____	_____
Sweating at night	____	____	Passage of dark urine or light stools	_____	_____
Headaches	____	____	Frequent urination	_____	_____
Trouble with Vision	____	____	Waking up at night to urinate	_____	_____
Bleeding from Nose or gums	____	____	Burning on urination	_____	_____
Hoarseness	____	____	Back or flank pain	_____	_____
Shortness of breath	____	____	Blood or pus in urine	_____	_____
Cough	____	____	Lightheadedness	_____	_____
Sputum production	____	____	Black out spells	_____	_____
Pleurisy	____	____	Fatigue	_____	_____
Chest Pain	____	____	Periods of confusion	_____	_____
Palpitations or Rapid heart beats	____	____	Excessive sleepiness	_____	_____
Ankle or leg swelling	____	____	Numbness/tingling in arms or legs	_____	_____
Nausea or vomiting	____	____	Pain in arms or legs	_____	_____

Patient Name: ______________________________

2. Have you ever had:

	Yes	No
High Cholesterol	____	____
Diabetes	____	____
Tuberculosis	____	____
Asthma/Bronchitis	____	____
Heart Disease	____	____
High Blood Pressure	____	____
Liver disease (jaundice, hepatitis)	____	____
Thyroid Problems	____	____
Stroke	____	____
Blood clots	____	____
Anemia	____	____
Easy bruising	____	____
Prolonged bleeding after dental extraction	____	____
Prolonged bleeding after surgery	____	____
Blood Transfusion	____	____
Transfusion reaction	____	____
Exposure to toxic chemicals/radiation	____	____

3. Do You? :

	Yes	No
Smoke cigarettes	_____	_____
Previous smoking history	_____	_____
Smoke cigars or a pipe	_____	_____
Drink alcohol daily	_____	_____

4. List DATE of your most recent:

Upper Endoscopy (EGD) ______________
Colonoscopy ______________
Complete Physical Exam ______________
Chest x-ray ______________

5. List all operations you have had:

Date	Type of Surgery	Hospital	Surgeon
__________________	______________________	________________	______________________
__________________	______________________	________________	______________________
__________________	______________________	________________	______________________

6. Health Maintenance (Women Only) ***please list last date of:***

Age of onset of periods ______________________
Do you take oral contraceptives? ______________
If yes, what age did you start? ________________
Number of pregnancies ______________________
Number of live born children __________________
How old where you when you had
your first live birth ? __________________
Number of miscarriages ______________________
Have you ever had abnormal vaginal bleeding? __________

Have you ever had a D&C? __________________
Age of Menopause ________________________
Do you take hormone
replacement therapy? ____________________
If yes, at what age did you start? ______________
Date of your last mammogram ________________
Date of your last pelvic exam __________________
Date of your last pap smear ___________________

Patient Name: ________________________________

7. Family History:

	Age	Past Illnesses	Current state of health or cause of death and cancer history
Parents:			
Mother	____	____________________________	____
Father	____	____________________________	____
Siblings:			
Sister	____	____________________________	____
	____	____________________________	____
	____	____________________________	____
	____	____________________________	____
Brother	____	____________________________	____
	____	____________________________	____
	____	____________________________	____
	____	____________________________	____

Have any of your relatives had a history of the following? :

	Yes	No
Diabetes mellitus	____	____
Tuberculosis	____	____
Allergies	____	____
High blood pressure	____	____
Heart Disease	____	____
Gout	____	____
Anemia	____	____
Bleeding disorder	____	____
Breast cysts	____	____
Cancer	____	____

If yes, what type? ____

____

Patient Name: ________________________________

8. Allergies: (*Please list any medication allergies* if you have no known allergies please write "none")

Drug	**Reaction**	**Drug**	**Reaction**
__________________	______________________	________________	______________________
__________________	______________________	________________	______________________
__________________	______________________	________________	______________________
__________________	______________________	________________	______________________

9. Supplements: Which supplements are you currently taking?

______________________________ ________________________ _________________________________

______________________________ ________________________ _________________________________

______________________________ ________________________ _________________________________

10. Medications*: list all that you are currently taking* (include all prescription drugs, and over the counter medications)

Drug	**Dose**	**Prescribing Doctor**
______________________________	________________________	_________________________________
______________________________	________________________	_________________________________
______________________________	________________________	_________________________________
______________________________	________________________	_________________________________
______________________________	________________________	_________________________________
______________________________	________________________	_________________________________
______________________________	________________________	_________________________________
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