

Name: _____

Past Medical History

Previous physician's name _____ Date of last exam _____

Do you have or have you been treated for:

Heart disease/Murmer/Angia	Yes/No	High cholesterol	Yes/No
High blood pressure	Yes/No	Low blood pressure	Yes/No
Heartburn (reflux)	Yes/No	Anemia/blood problems	Yes/No
Swollen ankles	Yes/No	Shortness of breath	Yes/No
Asthma	Yes/No	Lung problems/cough	Yes/No
Sinus problems	Yes/No	Tonsillitis	Yes/No
Ear problems	Yes/No	Eye disorder/glaucoma	Yes/No
Seizures	Yes/No	Stroke	Yes/No
Headaches/Migraines	Yes/No	Neurological problems	Yes/No
Depression/Anxiety	Yes/No	Psychiatric Care	Yes/No
Diabetes	Yes/No	Kidney/Bladder problems	Yes/No
Liver problems/Hepatitis	Yes/No	Arthritis	Yes/No
Cancer	Yes/No	Ulcers/colitis	Yes/No
Thyroid problems	Yes/No	Fainting	Yes/No

Have you ever been hospitalized? Yes/No If so, what for? _____

Have you been tested for hepatitis A, B, or C? Yes/No Which one? _____

Have you been vaccinated for hepatitis B? Yes/No If so, what date? _____

Have you been vaccinated for hepatitis B? Yes/No If so, what date? _____

When was your last Tuberculosis screening? _____ Result? Postive/Negative

If positive TB screening, when was your last chest x-ray? _____ Result? _____

Have you had a sexually transmitted disease? Yes/No Diagnosis: _____

List any past surgeries _____

Have you had any accidents as a result of which you are partially disabled? Yes/No If so, what and when? _____

Are you allergic to penicillin or any other drugs? Yes/No Which ones? _____

What medications are you taking? _____

Systems Review

Do you experience:

Fatigue	Yes/No	Weight loss/gain	Yes/No	Fevers	Yes/No
Night sweats	Yes/No	ENT	Yes/No	Cardiac	Yes/No
Respiratory	Yes/No	Sleep loss	Yes/No	GI	Yes/No
Dermatologic issues	Yes/No	Appetite changes	Yes/No	Hallucinations	Yes/No
Blurred vision	Yes/No	Double vision	Yes/No	Face numb/tingle	Yes/No
Tremor	Yes/No	Tinnitus	Yes/No	Incontinence	Yes/No
Vertigo/dizziness	Yes/No	Dysphagia	Yes/No	Trouble walking	Yes/No
Hoarseness	Yes/No	Weakness	Yes/No	Memory loss	Yes/No
Numbness	Yes/No	Stiffness/pain	Yes/No	Decreased hearing R/L	Yes/No
Smell/taste difficulty	Yes/No	Poor balance/coordination	Yes/No		

Social and preventative history

Occupation: _____

Do you currently smoke or chew tobacco? Yes/No If so, how many packs per day? _____

If not, have you in the past? Yes/No

Do you drink alcohol, beer, or wine? Yes/No If so, how many drinks per week? _____

If not, have you in the past? Yes/No

Do you currently drink coffee and/or tea? Yes/No If yes, how many cups per day? _____

Do you exercise daily/weekly? Yes/No

Do you use seatbelts while driving? Yes/No

Do you wear a helmet while riding a bike? Yes/No

Family History

	Living?	Age now (or at death)	Any serious illnesses
Mother	Yes/No	_____	_____
Father	Yes/No	_____	_____
Sisters	Yes/No	_____	_____
	Yes/No	_____	_____
	Yes/No	_____	_____
Brothers	Yes/No	_____	_____
	Yes/No	_____	_____
	Yes/No	_____	_____

Has any member (including children and parents) had any of the following illnesses? If so, which one?

	Relation		Relation
Anemia/blood disease	_____	Cancer	_____
Diabetes	_____	Glaucoma	_____
Heart disease	_____	High blood pressure	_____
HIV disease/AIDS	_____	Mental Illness	_____
Stroke	_____	Kidney disease	_____
Headache	_____	Epilepsy	_____
Other serious illness	_____		_____

Females

When was your last menstrual cycle? _____

How many times have you been pregnant? _____

Date of last mammogram _____ Mammogram results _____

Have you ever had a breast biopsy? Yes/No Biopsy results _____