Medical History Form

Name: _____

Date: _____

Family Medical History

	No History	Father	Mother	Brother	Sister	Son	Daughter	Other
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
CAD *(Coronary Artery Disease)*	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidimia *(High Cholesterol)*	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐

Medical History Form

The information you provide to your doctor is confidential and cannot be released without your authorization.

Name _____

Date _____

Medical Problems

- ☐ Stroke
- ☐ TIAs (mini strokes)
- ☐ Dementia
- ☐ High cholesterol
- ☐ Heart Disease
- ☐ High blood pressure

Year of last normal BP: _____

- ☐ Bone disease
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Emphysema
- ☐ Cancer
- ☐ Sleep apnea

- ☐ Kidney stones
- ☐ Prostate disease
- ☐ Kidney disease
- ☐ High/Low potassium
- ☐ Liver disease
- ☐ Diabetes type ☐1 ☐2

Year of onset: _____

Complications:

☐ Eye ☐ Kidney ☐ Nerve

- ☐ Gout
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Bowel disease
- ☐ Stomach ulcers
- ☐ Thyroid disease

- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Transfusions
- ☐ Anemia
- ☐ Blood clots
- ☐ Mental illness
- ☐ Other disorder

Pregnancies _____

Deliveries _____

For physician use
Mental illness

Hospitalizations

Please list all of your previous visits to the hospital, include ER visits and surgeries.

Reason for hospitalization	Date	For physician use

For physician use

Name: _____

Date of Service: _____

Interim Health Report

Please mark any changes in your personal or family medical history since your last visit

Family, Past, and Social History (if this is your first visit skip down to the Review of Systems)

Hospitalizations/Surgery: _____

If you have diabetes: When was your last eye appt? _____ When was your last foot exam? _____

New Medical Problems or Tests: _____

New Medications: _____

Deaths or illnesses in your family: _____

Last menstrual period or change in menses: _____

How much exercise do you get? _____

If you are getting iron infusions when was your last infusion? _____

Review of Systems

Have you experienced any of the following symptoms (problems) since your last visit (**Circle Yes or No**):

Constitutional

Fever/Chills	Yes	No
Weight Loss	Yes	No

Eyes

Visual Changes	Yes	No
Pain	Yes	No

Allergic/Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No

Endocrine

Heat/Cold Intolerance	Yes	No
Tired or Sluggish	Yes	No

Heart & Blood Vessels

Chest Pain	Yes	No
Heart Skip a Beat	Yes	No
Swelling of the Legs	Yes	No

Neurological

Dizziness	Yes	No
Numbness/Tingling	Yes	No

Psychological

Do you feel hopeless	Yes	No
Do you feel depressed	Yes	No

Gastrointestinal

Belly Pain	Yes	No
Diarrhea/Constipation	Yes	No
Nausea or Vomiting	Yes	No

Skin

Rash	Yes	No
Itching	Yes	No

Joints & Muscles

Joint, back, neck Pain	Yes	No
Muscle Pain	Yes	No

Hematological

Bruising/Bleeding	Yes	No
Transfusions	Yes	No

Ear, Nose & Throat

Ear/Throat Pain	Yes	No
Difficulty Hearing	Yes	No
Sinus Trouble	Yes	No

Bladder and Urination

Difficulty urinating	Yes	No
Incontinence	Yes	No
Urinary frequency	Yes	No
Abnormal vaginal bleeding	Yes	No

Respiratory

Wheezing	Yes	No
Cough	Yes	No
Shortness of breath	Yes	No
Loud snoring	Yes	No

_____

For physician use