Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

**COMPREHENSIVE PATIENT MEDICAL HISTORY FORM**

# PERSONAL INFORMATION:

Preferred Name: DOB: Date: Current Health Concerns:

**MEDICATIONS:** (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

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| **MEDICATION** | **DOSE** | **FREQUENCY** | **MEDICATION** | **DOSE** | **FREQUENCY** |
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**Drug Allergies or Reactions to Medications / Foods / Other Agents:** # Yes # No Please list:

**PERSONAL MEDICAL HISTORY:** Do you have any of the following?

# Acid Reflux (heartburn) # Alcoholism # Allergies (environmental)

# Anxiety # Asthma # Atrial Fibrillation

# Cancer (list below) # Cholesterol Problem # Coagulation (bleeding) Problem

# Chronic Low Back Pain # Depression # Diabetes

# Erectile Dysfunction # Gout # High Blood Pressure

# Heart Disease (explain below) # Migraines # Osteopenia / Osteoporosis

# Prostate Problems # Thyroid Problems

# Other Chronic or Recurring Medical Problems (Please list below)

Patient Name: Date:

**PRIOR SURGERIES AND HOSPITALIZATIONS:** # Yes # No (Please list all prior operations and hospitalizations)

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| --- | --- | --- | --- |
| **DATE** | **SURGERY OR HOSPITALIZATION** | **DATE** | **SURGERY OR HOSPITALIZATION** |
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Have you received a blood transfusion? # Yes # No When?

**FAMILY HISTORY:** Please indicate with a check any family members who have had any of the following conditions: Check here if you don’t know your family history #

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL CONDITION** | **M O M** | **D A D** | **B R O** | **S I S** | **D A U G** | **S O N** | **OTHER CLOSE RELATIVES** | **MEDICAL CONDITION** | **M O M** | **D A D** | **B R O** | **S I S** | **D A U G** | **S O N** | **OTHER CLOSE RELATIVES** |
| Alcoholism |  |  |  |  |  |  |  | Genetic Diseases |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  | Glaucoma |  |  |  |  |  |  |  |
| Anesthesia Problem |  |  |  |  |  |  |  | Allergies |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  | High Cholesterol |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  | Heart Disease (Heart attack, stent or bypass surgery) |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  | High Blood Pressure |  |  |  |  |  |  |  |
| Cancer, Breast |  |  |  |  |  |  |  | Kidney Disease |  |  |  |  |  |  |  |
| Cancer, Colon |  |  |  |  |  |  |  | Migraine Headaches |  |  |  |  |  |  |  |
| Cancer, Melanoma |  |  |  |  |  |  |  | Osteoporosis |  |  |  |  |  |  |  |
| Cancer, Other Skin |  |  |  |  |  |  |  | Rheumatoid Arthritis |  |  |  |  |  |  |  |
| Cancer, Ovary |  |  |  |  |  |  |  | Seizures |  |  |  |  |  |  |  |
| Cancer, Prostate |  |  |  |  |  |  |  | Strokes |  |  |  |  |  |  |  |
| Cancer (other list below) |  |  |  |  |  |  |  | Thyroid Disorders |  |  |  |  |  |  |  |
| Colon Polyps |  |  |  |  |  |  |  | Tuberculosis |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  | Other: |  |  |  |  |  |  |  |
| Diabetes, Type 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes, Type 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**COMPREHENSIVE PATIENT MEDICAL HISTORY FORM**

Patient Name: Date:

# SOCIAL HISTORY:

**Tobacco Use Alcohol Use**

Please check one Do you drink alcohol? # Y # N

# I have never smoked # never # occasionally # regularly

# I have smoked, but rarely Average # drinks/week? 5 oz. wine

When was the last time?

12 oz. beer

1.5 oz. hard liquor

# I have quit smoking. Quit Date: How many packs/day? How many yrs?

# I currently smoke pack(s)/day.

How many yrs.

Is alcohol use a concern for you or others? # Y # N

Other Tobacco: # pipe # cigar # snuff # chew **Drug Use**

Are you interested in quitting? # Y # N Do you use recreational drugs? # Y # N Have you ever used needles? # Y # N

# Sexual History

Are you sexually active? # Y # N # not currently Current sexual partner(s) is/are # male # female Birth control method:

Have you ever had any sexually transmitted diseases (STD’s)? # Y # N Date: Which STD? Are you interested in being screened for sexually transmitted diseases? # Y # N

# Exercise

Do you exercise? # Y # N How often? # Daily # 4 – 6x a week # 1 – 3x a week # less than one time a week

What form of exercise? (e.g., jogging, cycling, swimming)

# Safety

Do you use seat belts consistently? # Y # N Is violence at home a concern for you? # Y # N Are you currently in a relationship? # Y # N

If yes, do you feel safe in this relationship? # Y # N other concerns? **Socioeconomics**

Marital Status: # single # married # separated # divorced # widow

Occupation: Education completed: # grade school # high school # college # graduate school

Number of children: Who lives at home with you? Frequent foreign travel? # Y # N Where?

Patient Name: Date:

**Immunizations:** Please check any immunizations you were given and your best estimate of the month and year it was given. Tetanus: # Y # N Pneumonia: # Y # N Chicken Pox: # Y # N Hepatitis A: # Y # N Hepatitis B: # Y # N HPV (genital warts): # Y # N Shingles: # Y # N

# REVIEW OF SYSTEMS (please circle any *CURRENT* problems you have on the list below)

|  |  |  |
| --- | --- | --- |
| **General** | **Eyes** | **Genitourinary** |
| Fatigue / Weakness | Eye Pain | Frequent Urine Infections |
| Restless Sleep | Double Vision / Change in Vision | Painful Urination |
| Daytime Drowsiness | Itchy / Watery Eyes | Frequent Urination |
| Unhappiness | **Lungs** | Urinary Leakage / Incontinence |
| Depression / Sadness | Cough / Wheeze | Blood in Urine |
| Feeling “Blue” or Hopeless for More than 2 wks | Snoring / Gasping at Night During Sleep | Overnight Urination > 2 x |
| Lack of Motivation | Difficulty Breathing | Sexual Function Problems |
| Excessive Irritability | Positive TB Skin Test | **Male** |
| Feelings of Worthlessness | **Heart** | Decrease in Force of Urination |
| Nervous / Anxiety | Chest Pain / Pressure | Erection Problems |
| Unexplained Fever (> 100.0) | Recent Change in Exercise Tolerance | Testicle Lumps / Swelling |
| Frequent Night Sweats | Heart Murmur | **Female** |
| Unexplained Weight Loss | Palpitations / Irregular Pulse | Vaginal Discharge / Itching |
| Unexplained Weight Gain | Fainting Spells | History of Abnormal Pap Smear |
| Excessive Thirst | Swollen Ankles | Pain / Bleeding During Sex |
| **Skin** | Leg Pain with Walking / Exercise | Significant Pain / Cramps with Menses |
| Changes in Moles / Unusual Moles | **Gastrointestinal** | Hot Flashes / Night Sweats |
| Concerns re: skin spots / rashes / growths | Abdominal Pain | **Menstrual History** |
| Bruise Easily | Heartburn / Indigestion | Age of onset reg. / irreg. / menopause |
| Itching | Change in Bowel Habits – Recent | Flow: heavy / moderate / light |
| Excessive Hair Growth | Difficulty Swallowing | Length of cycle Days of flow |
| Hair Loss | Persistent Nausea / Vomiting | # of pregnancies # of births |
| **Ears / Nose / Throat** | Diarrhea / Constipation | # of miscarriages / abortions |
| Allergy Symptoms | Bloody or Black Tarry Stools | **Breast** |
| Hearing Loss | Frequent Laxative Use? How Often? | Pain / Lumps / Discharge |
| Ringing in the Ears | **Musculoskeletal** | **Neurological** |
| Dizzy Spells / Dizziness | Muscle / Joint Pain | Frequent Headaches |
| Nose Bleeds | Recurrent or Chronic Back Pain | Numbness / Tingling |
| Sinus Problems | Joint Swelling | Memory Loss |
| Hoarseness – Frequent | Gout | Tremor / Shaking |

Explanation: