

PAST MEDICAL HISTORY

Patient Name: _____

Date: _____

Chronic Medical Problems: _____

Hospitalizations / Surgeries / Injuries: _____

History of Blood Transfusion? Y N If yes, when? _____

Immunizations (Dates): Tetanus: _____ Other: _____

Last Tb Skin Test _____ Result _____

MEDICATIONS

DRUGS	DOSAGE	DRUGS	DOSAGE

Allergies: _____

SOCIAL HISTORY

Smoking History: Packs/day _____ Years _____ Quit _____

Alcohol: Drinks/day or week (please specify) _____ Other Drugs: _____

Marital Status: Never married Married Divorced Separated Widowed Partnered/significant other

Are you currently working? Yes No Hours/week _____ If not, are you retired disabled sick leave?

Do you receive disability or SSI? Yes No If yes, for what disability & how long? _____

FAMILY HISTORY

	If living		If deceased	
	Age (s)	Health Condition	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

Patient Name: _____

Date: _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- Recent weight gain; how much _____
- Recent weight loss: how much _____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

BLOOD

- Anemia
- Clots

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep

OTHER PROBLEMS: