

Patient Past & Present Medical History
PLEASE FILL OUT ENTIRE FORM

Patient Name: _____

Reason for Visit/Current Symptoms:

Surgery: (List any major operations you have had)

Year	Type of Operation	Please list any Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last Colonoscopy: _____

Last Endoscopy: _____

Hospitalizations:

Year	Reason you were hospitalized
_____	_____
_____	_____
_____	_____

Medications & Any over the Counter Meds: (List any drugs that you take regularly with doses and frequency)

Medication Name:	Dosage / Miligrams	How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies? YES NO

If yes, please list _____

Social History: (Check items which apply ONLY to the patient)

Tobacco: ___ Yes ___ No

Alcohol: ___ Yes or ___ No

If Yes, How Many Packs per Day? _____

If Yes, How Many Per Occasion? _____

Age Started _____

How many per week? _____

When Stopped: _____

***IF PATIENT IS A MINOR, WHO DO THEY LIVE WITH?** _____

FAMILY HISTORY:

Mother Date of Birth: ___/___/___ Living / Dead @ Age _____ List Health Problem(s) _____

Father Date of Birth: ___/___/___ Living / Dead @ Age _____ List Health Problem(s) _____

Check if Mom/Dad/Siblings has ever had, please use checkmark with M – Mom, D-Dad and S-Sibling:

Breast Cancer _____ Ovarian Cancer _____ Diabetes _____

Lung Cancer _____ Stomach Cancer _____ Stroke _____

Colon Cancer _____ Brain Cancer _____

Prostate Cancer _____ Heart Disease _____ Inherited Conditions: _____

****Please Only Check What Pertains to the Patient****

Constitutional

Weight Gain/Loss _____
 Fever _____
 Fatigue _____
 Chills _____
 Dizziness _____
 Cancer _____

Dermatology

Skin Cancers _____
 Recurrent Rashes _____
 Lump or Bumps _____
 Atypical Moles _____

HEENT

Loss of Hearing _____
 Cataracts _____
 Tonsillitis _____
 Difficulty Swallowing _____
 Ear Infections _____
 Glaucoma _____
 Frequent Nosebleeds _____
 Corrective Lenses _____
 Dentures _____
 Ringing in Ears _____

Pulmonary

Pneumonia _____
 Chronic Sputum _____
 Bronchitis _____
 Asthma _____
 Emphysema _____
 Tuberculosis _____
 Chronic Cough _____
 Pleurisy _____
 COPD _____
 Trouble Breathing _____
 Smoker _____

Cardiovascular

High Cholesterol _____
 High Blood Pressure _____
 Heart Valve Disease _____
 Heart Failure _____
 Shortness of Breath _____
 Angina (chest pain) _____
 Mitral Valve Prolapse _____
 Varicose Veins _____
 Palpitations (heart racing) _____
 Leg pain with Walking _____
 Atrial Fibrillation _____
 Heart Attack (MI) _____
 Stents _____
 Coronary Artery Bypass Graft _____

Gastrointestinal

Gastritis Peptic Ulcer Disease _____
 Blood in Stool or Vomitus _____
 Change in Bowel Habits _____
 Hemorrhoids _____
 Diverticulosis _____
 Hiatal Hernia _____
 Hepatitis _____
 Loss of Appetite _____
 Diarrhea _____
 Tar like Stools _____
 Reflux _____
 Crohn's Disease _____
 Gas Pain _____
 Constipation _____
 Change in Stools _____
 Gallstones _____
 Colitis _____
 Nausea _____
 Vomiting _____

Urinary

Kidney Stone _____
 Prostate Trouble _____
 Kidney or Bladder Infections _____
 Difficulty Voiding _____
 Blood in Urine _____

Musculoskeletal

Arthritis _____
 Back Pain _____
 Ankle Swelling _____
 Limitation of Range _____
 Limitation of Motion _____

Neuro

Stroke _____
 TIA _____
 Seizure _____
 Migraines _____

Psych

Depression _____
 Mental Illness _____

Hematology

HIV/AIDS _____
 Bleeding _____
 Received Blood _____
 Received Plasma _____
 Date Received _____
 Blood Disorder _____
 Clotting Disorder _____
 Pulmonary Embolism _____
 Deep Vein Thrombosis _____

Endocrine

Diabetes (Insulin/Non Insulin) _____
 Heat or Cold Tolerance _____
 Thyroid Problems _____
 Loss of Hair _____
 Goiter _____
 Change in Voice _____

Anesthesia

Reactions _____
 Nausea _____
 Vomiting _____

*Please list any other medical conditions: _____

PATIENTS 6 MONTHS AND OLDER: HAVE YOU HAD A FLU SHOT THIS SEASON? YES NO

PATIENTS 65 YEARS AND OLDER: HAVE YOU HAD A PNEUMONIA SHOT? YES NO