



Allergies _____

MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space. Please leave no blanks.

CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began:

	Problem	Date of Onset
1		
2		
3		
4		
5		

GENERAL HEALTH AND HABITS

Characterize your present health status: Excellent () Very Good () Average () Poor ()

Exercise

Do you exercise regularly? Yes No
 How long have you exercised on a regular basis?.....yrs
 Type of exercise(s).....
 How often.....days/week.....minutes each time

Nutrition

Vitamin/Mineral Supplements
 Your weight: 10 yrs ago..... 5 yrs ago.....now.....
 Your appetite: Excellent Good Fair Poor
 Are there foods you avoid (or limit) for health reasons?
 Specify:

Smoking

Do you smoke? Yes No
 How many per day?.....For how many years.....
 What do you smoke? Cigarettes Pipe
 Cigars Other (specify).....
 When did you quit smoking?.....years age

Alcohol/Beverages

Estimate the amount of alcohol you drink regularly:
drinks* per day.....drinks per week.....
 Did you formerly drink alcohol but have permanently stopped?
 Yes No

How long have (had) you smoked?.....yrs
 Do you use seat belts? Yes No
 Do you have smoke detectors? Yes No
 Do you use sunscreen? Yes No

Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink per day glasses, cups, or cans
 * one drink = 1 can beer, 4 oz. wine, or 1 1/2 oz. hard liquor

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete. Consult family, friends, physicians, etc.)

Operation	Hospital and City	Date

Have you ever been seriously injured? (If so, give details and date) _____

List chronologically all hospitalizations not already mentioned. (Do not include childbirth.)

Reason for Hospitalization	Hospital and City	Date

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

	NO	YES ? date of onset			NO	YES ? date of onset	
RESPIRATORY			PHYSICIAN'S COMMENT (Leave Blank)				
Have you ever had any of the following? (If so indicate when.)				Nausea or vomiting			
Pneumonia				Abdominal pain			
Severe bronchitis				Constipation			
Pleurisy				Diarrhea			
Tuberculosis skin test (Pos or Neg)				Has there been any change in your bowel functioning the last 6 mos.?			
Tuberculosis (infection or contact)				Have you ever had any of the following? (If so, indicate when.)			
Asthma (wheezing)				Hiatal or esophageal hernia			
Chronic bronchitis				Duodenal or gastric ulcer			
Emphysema				Vomiting of blood			
Exposure to dangerous dust or fumes				Black or tarry stools			
Trouble breathing				Blood in your stool or positive Blood Stool Cards			
Excessive snoring				Yellow jaundice			
Do you have chest pain?				Liver trouble or hepatitis			
Abnormal chest x-ray?				Gallbladder trouble or stones			
Have you ever coughed up blood?				Persistent diarrhea or colitis			
When was your last chest x-ray?				Diverticulitis			
				Hernia			
				Other digestive disease			
				When was your last: Colonoscopy			
CIRCULATORY							
Have you ever had any of the following? (If so, indicate when.)				JOINTS			
Chest pain				Have you ever had any of the following? (If so, indicated when.)			
Heart trouble				Muscle pain			
Heart attack (coronary)				Back pain			
High cholesterol				Joint pain			
High blood pressure				Joint swelling			
Blackouts				Gout			
Racing of heart				Has your doctor diagnosed arthritis, rheumatism?			
Heart failure							
Abnormal electrocardiogram							
Swelling of your ankles							
Have you ever taken heart or water pills?				CUTANEOUS			
When was your last EKG?				Have you ever had:			
				skin rashes			
				skin cancer			
ENDOCRINOLOGY							
Have you ever had any of the following? (If so, indicate when.)			URINARY				
Hormone problems			Have you ever had or been told you had any of the following? (If so, indicate when.)				
Thyroid disease			Kidney disease or nephritis				
Diabetes			Protein or albumin in urine				
Osteoporosis			Blood or pus in urine				
			Kidney stones				
			Urinary infection				
			Prostate trouble				
			Syphilis or gonorrhea				
DIGESTIVE							
Do you often or regularly have:							
Poor appetite							
Trouble swallowing							
"Heartburns"							
Regurgitation of food or bile							

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

	NO	YES ? date of onset			NO	YES ? date of onset
Do you have discomfort passing urine? .. Have you ever had a kidney x-ray(I.V.P.)			PHYSICIAN'S COMMENT (Leave Blank)	Stroke		
				Paralysis or muscular weakness		
OBSTETRIC & GYNOCOLOGICAL				Tremor or abnormal movements		
Have you ever had tumor(s), cyst(s), or other breast disease?				Difficulty with coordination		
How many times have you been pregnant (including miscarriages)?				Difficulty in walking		
How many live births? _____				Difficulty in speaking		
				Double vision or loss of vision		
At what age did you begin to menstruate _____				Numbness		
Have you ever had toxemia?				Difficulty with memory		
Have you had a hysterectomy?				Dizziness		
Are you now taking hormones or birth control pills?				MOOD		
When was your last Pap smear? _____				Have you recently:		
Have you had an abnormal Pap smear?				Experienced sever anxiety, panic or phobias?		
				Found it hard to concentrate?		
If you had your change of life: When was your last period? _____				Felt unable to enjoy your usual activities?		
Have you bled since?				Had a weight change or eating disorder?		
Last Mammogram _____				Felt excessively fatigued?		
				Felt depressed?		
HEMATOLOGY & ONCOLOGY				Have you ever:		
Have you ever had:				Had a nervous breakdown or psychiatric care?		
Anemia?				Had a drug or alcohol problem?		
Bleeding or bruising tendency?						
Cancer or tumor?				SPECIAL SENSE		
X-ray or radiation treatment				Have you ever had:		
Do you practice breast or testicular self exam				Glaucoma		
				Other major eye disease		
NEUROLOGICAL				Deafness		
Have you ever had any of the following? (If so, indicate when.)				Abnormal noises in the ear		
Neurological disease						
Frequent or recurrent headaches				ALLERGY & IMMUNOLOGY		
Loss of consciousness				Have you ever had:		
Convulsions or seizures				Asthma?		
Head injury				Eczema or other skin problems?		
				Hay fever or stuffy nose/sinuses?		
				A reaction to penicillin?		
				A reaction to aspirin?		
				A reaction to any other drug?(Specify) _____		
				Rubella (German Measles) status? ...		
				Date last immunized for:	YEAR	
				Tetanus-Diphtheria (every 10 yrs.)		
				Pneumococcal Pneonia(pneumovax)		
				Influenza (annual – Fall)		

CURRENT MEDICATIONS

List all the medications you are NOW taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list must be detailed, accurate, and complete; therefore consult with your family, druggist, physician. (Do not neglect aspirin and pain medication; hormones; contraceptives, water, diet, nerve or sleeping pills.)

Name of medicine	Strength of each dose	How often taken	When began taking

PERSONAL HISTORY

Where were you born? _____
 Have you ever lived or traveled extensively abroad? (If so, give details.) _____

 What is your occupation? _____
 Do you enjoy your work (retirement)? _____
 Have you ever worked in the field of medicine, in any capacity (Including volunteer, aide, clerk, technician)? _____
 What is the highest level of education you have attained? _____
 What inhaled chemicals or particles are you exposed to at your place of work? _____

List the areas you have lived in chronologically, giving dates:

Area	From	To

List your past occupations chronologically, giving date:

Occupation	From	To

FAMILY HEALTH

Please give the following information about the health of your immediate family:

RELATION	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			
Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

Diabetes _____ Cancer (Specify type if known) _____
 Migraine _____ Seizures or epilepsy _____ Any obscure or unusual disease _____
 Allergies _____ Blood disease _____ Abnormal bleeding or clotting _____
 Alcoholism _____ Psychiatric disease or suicide _____ A disease which "runs in the family" _____
 "Heart Attack" _____ High blood pressure _____ Kidney disease _____

Did you (the patient) fill out this form? Yes () No (), or did your spouse () or a friend () fill it out?

Signature of Patient _____