DELTA HEALTH

2117 Bentley Plaza ● Fenton, MO 63026 ● Phone (636) 825-2200 ● Fax (636) 825-2201

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Reason for Referral (current problems):

_____

_____

_____

_____

MEDICATIONS: List all prescription and over the counter drugs, their strength (mg) and # of tablets/day you are currently taking.					
Drug	Strength (mg,mcg)	Number Taken Per Day	Drug	Strength (mg, mcg)	Number Taken Per Day

ALLERGIES: List all known allergies, including medications and reactions	
Allergy:	**Reaction:**

MEDICAL HISTORY: Indicate if you have ever had any of the following:

Yes	No		Yes	No		Yes	No	
		AIDS			Diverticulosis			Kidney disease
		Anemia			Gallstones			Peptic ulcers
		Arthritis			Glaucoma			Stroke
		Asthma/emphysema/COPD			Hepatitis			Thyroid problem
		Diabetes			High blood pressure			Yellow jaundice
		Cancer (type):			STD infections (List):	List Accidents & Broken bones:		

Females Only: Number of Pregnancies:____ Number of live births: _____ Number of miscarriages:_____

Birth control method: _____ Have you experienced menopause? ☐Yes ☐NO

SURGICAL HISTORY: List all operations and hospitalizations and any complications

Year	Type of operation/hospitalization	Complications

FAMILY HISTORY: Indicate if your family has a history of these conditions by checking "F" for father, "M" for mother, and/or "S" for sibling. (May check more than one)

Heart Disease ☐F ☐M ☐S	Kidney problems ☐F ☐M ☐S	Diabetes ☐F ☐M ☐S	Seizure Disorder ☐F ☐M ☐S
Cancer (type) ☐F ☐M ☐S	Depression ☐F ☐M ☐S	Schizophrenia ☐F ☐M ☐S	Early senility ☐F ☐M ☐S
Alcoholism ☐F ☐M ☐S	Stroke ☐F ☐M ☐S	Obesity ☐F ☐M ☐S	
High blood pressure ☐F ☐M ☐S	Manic-depressive disorder ☐F ☐M ☐S	Other (specify): ☐F ☐M ☐S	

DELTA HEALTH

2117 Bentley Plaza ● Fenton, MO 63026 ● Phone (636) 825-2200 ● Fax (636) 825-2201

SOCIAL HISTORY: Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

☐Yes ☐No	Do you smoke? If YES, how many packs per day: If NO, have you ever smoked in the past?
☐Yes ☐No	Do you drink alcohol? If YES, what kind and how much: If NO, have you drunk alcohol in the past?
☐Yes ☐No	Do you use street drugs?
☐Yes ☐No	Have you ever had a blood transfusion? If yes, specify when:
☐Yes ☐No	Do you have any tattoos?
☐Yes ☐No	Do you have any history of IV drug use?

Symptoms

Check (√) conditions you currently have or have had in the past year.

General

☐Chills
☐Depression
☐Dizziness
☐Fainting
☐Fever
☐Forgetfulness
☐Headache
☐Loss of sleep
☐Loss of weight
☐Nervousness
☐Numbness
☐Sweats

Muscle/Joint/Bone

☐Arms ☐Hips
☐Back ☐Legs
☐Feet ☐Neck
☐Hands ☐Shoulders

Genito-urinary

☐Blood in urine
☐Frequent urination
☐Lack of bladder control
☐Painful urination

Gastrointestinal

☐Appetite poor
☐Bloating
☐Bowel changes
☐Constipation
☐Diarrhea
☐Excessive hunger
☐Excessive thirst
☐Gas
☐Hemorrhoids
☐Indigestion
☐Nausea
☐Rectal bleeding
☐Stomach pain
☐Vomiting
☐Vomiting blood

Cardiovascular

☐Chest pain
☐High blood pressure
☐Irregular heart beat
☐Low blood pressure
☐Poor circulation
☐Rapid heart beat
☐Swelling of ankles
☐Varicose Veins

Eye, Ear, Nose, Throat

☐Bleeding gums
☐Blurred vision
☐Crossed eyes
☐Difficulty swallowing
☐Double vision
☐Earache
☐Ear discharge
☐Hay fever
☐Hoarseness
☐Loss of hearing
☐Nosebleeds
☐Persistent cough
☐Ringing in ear
☐Sinus problems
☐Vision-flashes
☐Vision-halos

Skin

☐Bruise easily
☐Hives
☐Itching
☐Change in moles
☐Rash
☐Scars
☐Sore that won't heal

Men Only

☐Breast lump
☐Erection difficulties
☐Lump in testicles
☐Penis discharge
☐Sore on penis
☐Other

Women Only

☐Abnormal Pap Smear
☐Bleeding between periods
☐Breast lump
☐Extreme menstrual pain
☐Hot flashes
☐Nipple discharge
☐Painful intercourse
☐Vaginal discharge
☐Other

Date of last menstrual period:
_____

Date of last pap smear:
_____

Have you had a mammogram?
_____

Are you pregnant?_____

Number of children:_____