Patient Medical History

Full Name: _____ Date: _____
Birth Date: _____ Age: _____

Allergies

Are you allergic to any medications, X-Ray dyes, or other substances? ☐ Yes ☐ No	
ALLERGY	ALLERGIC REACTION

If you need more room to list allergies, please write them on the back of this sheet with the required information.

Medications

Are you currently taking any medications? (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) ☐ Yes ☐ No

MEDICATIONS (Please list ALL)	DOSE (Mg, pill, etc)	TIMES PER DAY

If you need more room to list medications, please write them on the back of this sheet with the required information.

Labs/Screenings

When was the last time you had the following tests or screenings done?			
CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No
PROSTATE EXAM	Date:	Facility/Provider:	Abnormal Result? ☐ Yes ☐ No

Vaccinations

When was the last time you had the following vaccinations or boosters?	
Tetanus Booster or TdaP:	Allergic Reaction
Flu Vaccine:	Pnuemovax *(Pneumonia)*:
Zoster Vaccine *(Shingles)*:	Hepatitis B:

Patient Medical History

Diseases/Conditions	Have you been diagnosed with any of the following diseases or conditions?		
	Alcoholism	☐ Yes ☐ No ☐ Past	Comments:
	Asthma	☐ Yes ☐ No ☐ Past	Comments:
	Cancer (type:_____)	☐ Yes ☐ No ☐ Past	Comments:
	Depression/Anxiety/Bipolar/Suicidal	☐ Yes ☐ No ☐ Past	Comments:
	Diabetes (type:_____)	☐ Yes ☐ No ☐ Past	Comments:
	Emphysema (COPD)	☐ Yes ☐ No ☐ Past	Comments:
	Heart Disease	☐ Yes ☐ No ☐ Past	Comments:
	High Blood Pressure (hypertension)	☐ Yes ☐ No ☐ Past	Comments:
	High Cholesterol	☐ Yes ☐ No ☐ Past	Comments:
	Hypothyroidism/Thyroid Disease	☐ Yes ☐ No ☐ Past	Comments:
	Renal (kidney) Disease	☐ Yes ☐ No ☐ Past	Comments:
	Migrain Headaches	☐ Yes ☐ No ☐ Past	Comments:
	Stroke	☐ Yes ☐ No ☐ Past	Comments:
	Tuberculosis	☐ Yes ☐ No ☐ Past	Comments:
	Heptatitis	☐ Yes ☐ No ☐ Past	Comments:
	HIV/AIDS	☐ Yes ☐ No ☐ Past	Comments:

Family History	Have any members of your family (including parents, grandparents, and siblings) ever had any of the following? Which family members?		
	ILLNESS	WHICH FAMILY MEMBER(S)?	AGE WHEN DIAGNOSED
	Cancer (type)		
	Hypertension (high blood pressure)		
	Heart disease		
	Diabetes		
	Strokes		
	Mental Disorders		
	Drug or Alcohol Addiction		
	Glaucoma		
	Bleeding diseases		
	Other		

Patient Medical History

Surgeries	TYPE (Specify left/right)	DATE	LOCATION/FACILITY

Gynecologic/Obstetrics History			
	Date of Last Menstural Cycle:		Age of Menopause:
	Age at onset of periods:	Frequency:	Length of period:
	Total Number of Pregnancies:	Number of Live Births:	Miscarriages:
	Prolonged or abnormal bleeding. ☐ No ☐ Yes (Please Describe)		
	Leakage of Urine. ☐ No ☐ Yes (Please Describe)		
	Pelvic Pain ☐ No ☐ Yes (Please Describe)		
	Abnormal Discharge ☐ No ☐ Yes (Please Describe)		
	History of Abnormal Pap Smear ☐ No ☐ Yes (Please Describe)		

Tobacco, Drugs, & Alcohol				
	TOBACCO USE	**Do you smoke cigarettes?** ☐ Yes ☐ No		
	Current: Packs/day: # of years:		**Past:** Quit Date: Packs/day: # of years:	
	Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape ☐ Hookah How Often?			
	ALCOHOL/DRUGS	Do you drink alcohol? ☐ Yes ☐ No	☐ Beer ☐ Wine ☐ Liquor	# of drinks/week:
	Do you use marijuana or recreational drugs? ☐ Yes ☐ No		Which drug(s)?	
	Have you ever used needles to inject drugs? ☐ Yes ☐ No		Have you ever taken someone else's drugs? ☐ Yes ☐ N	

Other Providers/Specialists	Are you currently under the care of any other doctors or specialists? ☐ Yes ☐ No		
	Cardiology		
	Gastroenterologist (GI)		
	OB/Gyn		
	Neurology		
	Pulmonary		
	Other:		

Patient Medical History

Review of Systems

CONSTITUTION	GASTROINTESTINAL	SKIN
☐ Activity Change	☐ Abdominal distention	☐ Color change
☐ Appetite Change	☐ Abdominal pain	☐ Pallor
☐ Chills	☐ Anal bleeding	☐ Rash
☐ Diaphoresis	☐ Blood in stool	☐ Skin diseases
☐ Fatigue	☐ Change in bowel habits	☐ Wound
☐ Fever	☐ Colitis	ALLERGY/IMMUNO
☐ Unexpected weight change	☐ Constipation	☐ Environmental allergies
HEAD, EAR, NOSE & THROAT	☐ Diarrhea	☐ Food allergies
☐ Congestion	☐ Indigestion	☐ Immunocompromised
☐ Dental problems	☐ Nausea	NEUROLOGICAL
☐ Drooling	☐ Rectal pain/Hemorrhoids	☐ Dizziness
☐ Ear discharge	☐ Vomiting	☐ Facial asymmetry
☐ Ear pain	ENDOCRINE	☐ Headaches
☐ Facial swelling	☐ Cold intolerance	☐ Light-headedness
☐ Hearing loss	☐ Heat intolerance	☐ Numbness
☐ Mouth sores	☐ Polyphagia (extreme hunger)	☐ Seizures
☐ Nosebleeds	☐ Polyuria (excessive urine)	☐ Speech difficulties
☐ Postnasal drip	GENITOURINARY	☐ Syncope
☐ Rhinorrhea	☐ Difficulty urinating	☐ Tremors
☐ Sinus pressure	☐ Dysuria (painful urination)	☐ Weakness
☐ Sneezing	☐ Enuresis (involuntary urination)	HEMATOLOGIC
☐ Sore throat	☐ Erectile Dysfunction	☐ Adenopathy
☐ Tinnitus	☐ Flank pain	☐ Anemia
☐ Trouble swallowing	☐ Frequent urination	☐ Blood disorders
☐ Voice change	☐ Genital sore	☐ Bruises/bleeds easily
EYES	☐ Hematuria (blood in the urine)	PSYCHIATRIC
☐ Eye discharge	☐ Penile discharge	☐ Agitation
☐ Eye itching	☐ Penile pain	☐ Behavior problem
☐ Eye pain	☐ Penile swelling	☐ Confusion
☐ Eye redness	☐ Scrotal swelling	☐ Decreased concentration
☐ Photophobia	☐ Testicular pain	☐ Dysphoric mood
☐ Visual disturbance	☐ Urgency	☐ Hallucinations
RESPIRATORY	☐ Urine decreased	☐ Hyperactive
☐ Apnea	☐ Venereal disease	☐ Nervous/anxious
☐ Bronchitis	MUSCULAR	☐ Self-injury
☐ Chest pain	☐ Back pain	☐ Sleep disturbance
☐ Chest tightness	☐ Gait problems	☐ Suicidal ideas
☐ Choking	☐ Gout	CARDIOVASCULAR
☐ Persistent cough	☐ Joint swelling	☐ Chest pain
☐ Shortness of breath	☐ Myalgias (muscle aches)	☐ Leg swelling
☐ Stridor	☐ Neck pain	☐ Palpitations
☐ Pneumonia	☐ Neck stiffness	

Patient Medical History

Lifestyle	SEXUAL ACTIVITY	Are you sexually involved currently? ☐ Yes ☐ No		
	My sexual partner(s) is/are/have been: ☐ Male ☐ Female ☐ Transgender			
	Birth control method: ☐ None ☐ Condom ☐ Pill/Patch/Inj./IUD ☐ Vasectomy			
	Have you ever engaged in any activity which has put you at risk of contracting HIV/AIDS? ☐ Yes ☐ No			
	Would you like to be tested for HIV? ☐ Yes ☐ No			
	EXERCISE	Do you exercise regularly? ☐ Yes ☐ No		
	What kind of exercise?		How long (min):	How often:
	SLEEP	How many hours, on average, do you sleep?		
	DIET	How would you rate your diet? ☐ Good ☐ Fair ☐ Poor	Would you like advice on your diet? ☐ Yes ☐ No	
	SAFETY	Do you use a bike helmet? ☐ Yes ☐ No	Do you use seat belts consistently? ☐ Yes ☐ No	
	Have you ever worked with any chemicals, paints, asbestos, or other hazardous materials? ☐ Yes ☐ No		If you have a gun in the home, do you keep it unloaded and/or locked up? ☐ Yes ☐ No ☐ N/A	
	Working smoke detectors in the home? ☐ Yes ☐ No		Do you ever feel afraid of your partner? ☐ Yes ☐ No	
	Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ Yes ☐ No		Have you completed an Advanced Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? ☐ Yes ☐ No	
	WORK	Occupation:	☐ Employed ☐ Disabled ☐ LOA ☐ Unemployed ☐ Retired	
	Employer:		Years of Education or Highest Degree:	
	If employed, do you work the night shift? ☐ Yes ☐ No			
	FAMILY	Marital Status: ☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed ☐ Other:		
	Do you have children? ☐ Yes ☐ No		If yes, how many?	

Additional Info	Have you traveled outside of the country in the last 30 days? ☐ Yes ☐ No	If so, where?
	Have you served in the military? ☐ Yes ☐ No	How long and which branch?
	Were you deployed? ☐ Yes ☐ No	If yes, where?

Is there anything else you feel the doctor may need to know about your medical history?

_____

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