MARINA VILLAGE MEDICINE

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PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth_____

Reason for today's visit _____

PREVENTIVE HISTORY

Check all that apply and provide date of diagnosis or test:

			Year of Diagnosis			
High Blood Pressure	☐ yes	☐ no				
High Cholesterol	☐ yes	☐ no				
Diabetes	☐ yes	☐ no				
			Year of Test:	**Where was it prerformed:**		
Colonoscopy	☐ yes	☐ no			☐ Normal	☐ Abnormal
Bone Density Test	☐ yes	☐ no			☐ Normal	☐ Abnormal
Heart Stress Test	☐ yes	☐ no			☐ Normal	☐ Abnormal
Heart Catheterization	☐ yes	☐ no			☐ Normal	☐ Abnormal
Urinary Incontenance	☐ yes	☐ no			☐ Normal	☐ Abnormal
Male Patients						
PSA Test	☐ yes	☐ no			☐ Normal	☐ Abnormal
Female Patients						
Mammogram	☐ yes	☐ no			☐ Normal	☐ Abnormal
Pap Smear	☐ yes	☐ no			☐ Normal	☐ Abnormal

Number of Pregnancies: _____ Number of Births: _____ Date of Last Menstral Period _____

CURRENT MEDICATIONS

What medicatons are you currently taking?

Name	Dosage	Frequency

ALLERGIES

Please list any known allergies

HOSPITALIZATIONS, PROCEDURES OR SURGERIES

Please list any surgeries, procedures or recent hospitalizatons (continue on back, if necessary):

Reason	Hospital	Date
Reason	Hospital	Date
Reason	Hospital	Date

FAMILY HISTORY

Anyone in your immediate family had the following: Details:

- ☐ Alcoholism
- ☐ AIDS/HIV
- ☐ Blood Clots
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Osteoperosis
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Blood Disorder
- ☐ Cancer

IMMUNIZATIONS

List the date and location where you received the following vaccines:

				Office/Pharmacy:	City/Street:
Influenza	Y	N	Date		
Tetanus	Y	N	Date		
Pneuococcal	Y	N	Date		
Prevnar 13	Y	N	Date		
DTAP/Whooping Cough	Y	N	Date		
Zoster/Shingles	Y	N	Date		
Varicella	Y	N	Date		
Other	_____		Date		

SOCIAL HISTORY/LIFESTYLE

Please tell us a little about your lifestyle:

Occupation: _____

Exercise: Type? _____ How long? _____ How often? _____ times per week

	Current Use		Past Use		How often per week	How much per day
Smoking	Y	N	Y	N		
Caffeine	Y	N	Y	N		
Alcohol	Y	N	Y	N		
Drug Use	Y	N	Y	N		

SELF EVALUATION

Give us some information about your ability to care for yourself

How would you rate your health in general? ____excellent ____good ____fair ____poor

Are you confident in handling your health and health problems? _____yes _____no

REVIEW OF SYSTEMS

Please check any that you have experienced in the last 3 months

CONSITUTIONAL			**GASTROINTESTINAL**		
Y	N	Changes in appetite	Y	N	Black, tarry stool
Y	N	Night sweats	Y	N	Bloody stool
Y	N	Fever	Y	N	Constipation
Y	N	Chills	Y	N	Heartburn
Y	N	Fatigue	Y	N	Indigestion
Y	N	Recent weight gain (____lbs)	Y	N	Vomitting/Nausea
Y	N	Recent weight loss (____lbs)	Y	N	Abdominal pain or cramping
URINARY			**CARDIOVASCULAR**		
Y	N	Blood in urine	Y	N	Fainting
Y	N	Painful urination	Y	N	Fast heart rate
Y	N	Urinating at night	Y	N	Irregular heart beat
Y	N	Involuntary loss of urine	Y	N	Chest pain
Y	N	Painful intercourse	Y	N	Swelling of extremities
Y	N	Menstral irregularities	Y	N	Difficulty breathing while layig down
ENDOCRINE			**PSYCHIATRIC**		
Y	N	Increased thirst	Y	N	Anxiety
Y	N	Heat/Cold intolerance	Y	N	Suicidal thoughts
Y	N	Excessive urination	Y	N	Substance abuse
Y	N	Skin, hair or fingernail changes	Y	N	Little interest/pleasure in doing things
NEUROLOGICAL			**SKIN**		
Y	N	Numbness	Y	N	Change in moles or warts
Y	N	Headaches	Y	N	Rash
Y	N	Fainting	Y	N	Sores that will not heal
Y	N	Loss of Balance	Y	N	Yellowing of the skin
EYES			**RESPIRATORY**		
Y	N	Recent change in vision	Y	N	Wheezing
Y	N	Double vision	Y	N	Cough
Y	N	Eye pain	Y	N	Sortness of breath with normal activity
MUSCULOSKELETAL			**HEME/LYMPH**		
Y	N	Joint pain	Y	N	Easy bruiusing
Y	N	Muscle pain	Y	N	Enlarged lumph nodes
Y	N	Prolonged morning joint pain	Y	N	New breast lumps
EAR, NOSE, AND THROAT			**EAR, NOSE, AND THROAT**		
Y	N	Loss of hearing	Y	N	Hoarseness
Y	N	Nasal congestion	Y	N	Ringing in the ears
Y	N	Snoring	Y	N	Seasonal allergies
Y	N	Trouble swallowing	Y	N	Cold symptions

Signature of Patient or Agent/Guardian Date