MEDICAL HISTORY

1. NAME

_____
LAST FIRST

CIRCLE ALL THAT APPLY: Male Female
Black (non-Hispanic) Hispanic Native American
White (non-Hispanic) Asian/Pacific Islander

2. MEDICATIONS
List all medication (prescription and non-prescription) you currently take:

_____ _____ _____
_____ _____ _____

3. IMMUNIZATIONS
Year of your last tetanus booster _____
If born after 1956,
date of last Measles booster _____

4. ALLERGIES
To which of the following are you allergic?
☐ Drugs (specify below) ☐ Pollens ☐ Animals
☐ Other (specify below) ☐ Dust or Molds ☐ Food

_____ _____
_____ _____

5. MEDICAL HISTORY
Which of the following conditions have you ever had?
Enter year of diagnosis, if known; or place, if known.

☐ Head Injury	☐ Diabetes
☐ Positive skin test for TB	☐ Arthritis
☐ Migraines	☐ High Blood Pressure
☐ Active Tuberculosis	☐ Gout
☐ Seizures	☐ Heart Murmur
☐ Ulcers	☐ Herniated Disc
☐ Glaucoma	☐ Rheumatic Fever
☐ Sexually Transmitted Disease	☐ Hepatitis
☐ Stroke	☐ Heart Attack
☐ Gallstones	☐ Anemia
☐ Cataracts	☐ Pneumonia
☐ Bladder Infections	☐ Tumors
☐ Thyroid Trouble	☐ Asthma
☐ Kidney Stones	☐ Cancer
☐ Depression/Anxiety	☐ Emphysema

Other medical and/or psychiatric disorders—Specify: _____
_____
_____

6. SOCIAL HISTORY
Have you ever smoked? ☐ Yes ☐ No
If yes, when: ☐ Current ☐ Past, Years since quitting: _____
How many per day? _____ For how many years? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, when? ☐ Weekdays ☐ Weekends ☐ Both
Do you ever: ☐ Drink in the morning? ☐ Binge drink?

Sexual Preference (optional):
☐ Heterosexual ☐ Homosexual ☐ Bisexual

Type of Safer Sex Used: ☐ Abstinence ☐ Condoms ☐ Monogamy ☐ None

Do you use Recreational Drugs? ☐ Yes ☐ No

Do you have Advanced Directives? ☐ Yes ☐ No

7. OCCUPATIONAL HISTORY: Briefly describe the activities of your current job: _____
_____

8. HOSPITALIZATIONS AND SURGERIES

YEAR	REASON
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9. FAMILY HISTORY: Which of the following have your **parents**, **brothers**, **sisters** or **children** ever had?

☐ Thyroid Disease	☐ Depression/Suicide
☐ Heart Trouble or Disease	☐ Alcoholism
☐ Cancer or Leukemia	☐ Tuberculosis
☐ High Blood Pressure	☐ Asthma
☐ Kidney Trouble	☐ Stroke
☐ High Cholesterol	☐ Diabetes

10. REVIEW OF SYSTEMS: Which of the following have been a problem for you in the last year?

☐ Generalized weakness	☐ Hoarseness	☐ Hemorrhoids	**MEN ONLY**
☐ Unexplained weight gain/loss	☐ Difficulty swallowing	☐ Headaches	Last PSA Test
☐ Excessive fatigue	☐ Chest pain or pressure	☐ Dizziness	Month: _____ Year: _____
☐ Swollen glands	☐ Palpitations/Skipped beats	☐ Passing out/Fainting	☐ Prostate disorder
☐ Loss of appetite	☐ New or change in cough	☐ Numbness or tingling	☐ Testicular disorder
☐ Change in vision	☐ Coughing up blood	☐ Excessive sadness/Anxiety	☐ Penile discharge
☐ Discharge, eyes	☐ Wheezing	☐ Insomnia/Difficulty sleeping	☐ Impotence
☐ Earaches	☐ Shortness of breath	☐ Back pain	**WOMEN ONLY**
☐ Difficulty Hearing	☐ Heartburn	☐ Neck pain	☐ Irregular periods/spotting
☐ Ringing/Buzzing	☐ Nausea/vomiting	☐ Joint pain	☐ Vaginal discharge
☐ Sinus trouble	☐ Diarrhea	☐ Moles that changed in size/color	☐ Breast lump/discharge
☐ Congestion	☐ Constipation	☐ Rashes	☐ Currently or possibly pregnant
☐ Sneezing/runny nose	☐ Frequent urination	Last Colonoscopy/Sigmoidoscopy	Last Pap Smear
☐ Nosebleeds	☐ Difficult or painful urination	Month: _____ Year: _____	Month: _____ Year: _____
☐ Mouth sores	☐ Loss of bladder control		Last Mammogram
	☐ Rectal bleeding/tarry stools		Month: _____ Year: _____

_____ _____ _____
Patient Signature Date Examiner Reviewed