MEDICAL HISTORY

Name _____

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space.

CHIEF COMPLAINT

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

Problem	Date of Onset

GENERAL HEALTH

Do you consider yourself basically healthy now? Yes No Have you been well most of your life? Yes No

When did you last feel well? _____

How is your overall "pep" now compared with a year ago? Increased Decreased About the same

Has there been a net change in your weight in the past year (if so , indicate how much)? _____

Have you been having fever lately? Yes No Do you usually sleep well? Yes No

How much and what kind of physical exercise do you get? _____

What do you do in your spare time? _____

In the past year, has there been any change in you:

Marital Status? _____ Work or job? _____ Residence? _____

Spare time Activity? _____ Physical activity? _____ Drinking habits? _____

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all surgeries and hospitalizations you have had:

Reason for Hospitalization/Surgeries	Date

Have you ever been seriously ill (if yes, please give details)? _____

Have you ever had any of the following?

Thyroid disease _____ Anemia _____ Diabetes _____ Bleeding tendency _____

Cancer _____ Syphilis _____ Gonorrhea _____ Tropical Disease _____

Name _____

Please check (√) box for YES answer. Leave blank for NO answer. Use space provided to elaborate.

GYNECOLOGY & OBSTETRIC	YES	*extra writing space below*
Have you ever had tumor(s),		
cyst(s) or other breast disease?		
How many times have your		
been pregnant? _____		
How many live births?_____		
Do you ever bleed (spot)		
between periods?		
after intercourse?		
At what age did you begin to		
menstruate? _____		
Have you ever had toxemia?		
Have you had a hysterectomy?		
Are you now taking hormones		
or birth control pills?		
When was your last PAP		
smear? _____		
If you are still menstruating		
When was your last		
period? _____		
The one before? _____		
How many days do your periods		
usually last? _____		
Are your periods regular?		
What is your cycle		
length? _____		
If you are going thru menopause		
When was your last		
period? _____		
Have you bled since?		
ALLERGY		
Have you ever had:		
Sinusitis		
Hives		
Rash or other skin problems		
Hay fever or stuffy nose		
Other allergy		
Have you ever had a bad		
reaction to any medication?		
If yes, please list them below		
_____		
_____		
_____		
_____		
_____		

NEUROLOGICAL	YES
Have you ever had any of the	
following (if yes, indicate when)?	
Frequent or recurrent headaches	
Loss of consciousness	
Neurological disease	
A head injury	
Stroke	
Paralysis	
Uncontrollable movements	
Difficulty with coordination	
Difficulty walking	
Difficulty in speaking	
Double vision	
Numbness	
Hallucinations	
Nervous breakdown	
Psychiatric condition	
Severe depression or nervousness	
Crying spells	
Difficulty with memory	
Difficulty with arithmetic	
HEMATOLOGY	
Have you ever had any of the	
following (if yes, indicate when)?	
Anemia	
Bleeding or bruising tendency	
Cancer	
X-ray therapy	
SPECIAL SENSES	
Have you ever had:	
Glaucoma	
Other major eye disease	
Deafness	
Abnormal noises in the ear	
Have you had a TB skin test?	
If yes, was it positive?	
Have you been immunized for:	
Polio	
Tetanus	
Others	
Have you tested positive for HIV	

PERSONAL HISTORY

Name _____

Where were you born?_____ Have you ever lived or traveled abroad (if yes, where)? _____

What is your occupation? _____ Do you enjoy your work? _____

What is the highest level of education you have obtained? _____

Areas you have lived in, in chronological order.	**From** (date)	**To** (date)

FAMILY HEALTH

Relationship	**Age or age at death**	**State of health or cause of death**
Mother		
Father		
Sisters		
Brothers		
Children		
Spouse		

Have any blood relatives ever had any of the following (if yes, indicate relationship to you)?

Diabetes _____ Cancer _____ Gout _____ High blood pressure _____

Rheumatoid arthritis _____ Blood disease _____ Any obscure or unusual disease _____

TB _____ Allergies _____ Alcoholism _____ Psychiatric disease _____

Please list ALL medications you are currently taking.

	Medications and Dosages	**6am**	**8am**	**10am**	**12pm**	**2pm**	**4pm**	**6pm**	**8pm**	**10pm**
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										

Name _____

Please check (√) box for YES answer. Leave blank for NO answer. Use space provided to elaborate.

RESPIRATORY	**YES**	*extra writing space below*
Have you ever had any of the		
following (if yes, indicate when)?		
Pneumonia		
Severe bronchitis		
Pleurisy		
TB		
Asthma		
Chronic bronchitis		
Emphysema		
Other lung trouble		
Have you ever coughed up blood?		
Do you often or regularly:		
cough?		
Raise sputum?		
get colds?		
Do colds tend to "settle" in your chest?		
Do you smoke?		
How many a day?		
How long have you smoked?		
Did you formerly smoke?		
When did you quite?		
When was your last chest x-ray?		
Have you ever had an abnormal x-ray?		
CIRCULATORY		
Have you ever had any of the		
following (if yes, indicate when)?		
Heart trouble		
Heart murmur		
Heart attack		
Angina Pectoris		
High cholesterol		
High blood pressure		
Rheumatic fever		
St. vitus dance		
Heart failure		
Abnormal electrocardiogram (ECG)		
normal electrocardiogram (ECG)		
Have you ever taken heart or		
water pills?		
JOINTS		
Have you ever had any of the		
following (if yes, indicate when)?		
A disk problem		
Sciatica		
Swelling of joint(s)		
Rheumatoid arthritis		
Gout		

DIGESTIVE	**YES**
Do you often or regularly have:	
Trouble swallowing	
"Heartburn"	
Feed "repeating"	
Nausea or vomiting	
Abdominal pain	
Constipation	
Diarrhea	
Has there been any change in you	
appetite in the last six months?	
Has there been any change in your	
bowel function in the last six months?	
Have you ever had any of the	
following (if yes, indicate when)?	
Ulcer	
Hiatal or esophagus hernia	
Vomiting of blood	
Black or tarry stools	
Yellow jaundice	
Liver trouble	
Gallbladder trouble or stones	
Pancreatitis	
Persistent diarrhea	
Colitis or dysentery	
Diverticulitis	
Blood in your stool	
Hemorrhoids	
Hernia	
Other digestive disease	
Abdominal surgery	
X-rays of:	
Stomach (GI series)	
Gallbladder	
Bowel (barium enema)	
URINARY	
Have you ever had any of the	
following (if yes, indicate when)?	
Kidney disease or nephritis	
Protein or albumin in urine	
Blood or puss in urine	
Kidney stones	
Bladder infection (cystitis)	
Prostate trouble	
Syphilis or gonorrhea	
How many times do you urinate:	
at night _____	
during the day _____	
Have you ever had a kidney	
x-ray (IVP)	