Date of Birth: ____________

Patient Name: ____________

PATIENT MEDICAL HISTORY SHEET

Vaccines	Approximate Date
Tetanus	
Flu	
Hep B	
Pneumovax	
MMR	
Chicken Pox	
TB skin test Positive Negative	

Exams	Approximate Date
Last Dental exam	
Last Eye exam	
Last Chest X-ray	
Last Colonoscopy/Sigmoidoscopy	
Last Mammogram	
Last Pap Smear	
Last Physical Exam	
Last Prostate Exam/PSA	
Other	

Has any blood relative had any of the following: Circle 'yes' or 'no'.
If so, what relationship:

Condition			Relationship
Anemias	yes	no	
Bleeding tendency	yes	no	
Leukemia	yes	no	
Repeated infections	yes	no	
Crippling arthritis	yes	no	
Heart diseases	yes	no	
Tuberculosis	yes	no	
High blood pressures	yes	no	
Kidney diseases	yes	no	
Asthma	yes	no	
Severe allergies	yes	no	
Mental illness	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Thyroid trouble	yes	no	
Peptic ulcers	yes	no	
Chronic diarrheas	yes	no	
Cancer	yes	no	

	Present Age or Age at Death	If Living, health (good, fair or poor) If deceased, cause of death
Father:		
Mother:		
Brother/Sisters:		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Children:		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Current Medications – Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

Past hospitalizations/surgeries/serious injuries
(including blood transfusions)

Birth Control ***(Oral, Injectable)***

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

INDICATE WHICH APPLY TO YOU

GENERAL	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite/thirst change	☐	☐
4. Excessive fatigue/nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged/tender lymph nodes or glands	☐	☐
7. Other ____________________		

EYES	Yes	No
1. Do you wear glasses/contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Other ____________________		

EARS	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing/ringing	☐	☐
6. Feel "stopped up"	☐	☐
7. Other ____________________		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness/drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores/ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth/gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea *(stop breathing) while sleeping)*	☐	☐
10. Other ____________________		

PULMONARY	Yes	No
1. Shortness of breath/difficulty	☐	☐
breathing	☐	☐
2. Cough-dry/productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever/chills	☐	☐
6. Other ____________________		

GASTROINTESTINAL	Yes	No
1. Heartburn / indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea / vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools / diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black/bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems / jaundice / hepatitis	☐	☐
14. Gallstones		
15. Other ____________________		

BREAST	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other ____________________		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain / lumps / swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA ____________		
8. Venereal disease		
9. Genital concerns		
10. Other ____________________		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause / symptoms	☐	☐
7. Trouble conceiving	☐	☐
8. Problems with pregnancies	☐	☐
9. Sexual difficulties	☐	☐
10. Venereal disease	☐	☐
11. Genital concerns	☐	☐
12. Self breast exams per year ______		
13. Do you use birth control	☐	☐
Type ____________________		
14. Date of last pap ____________		
15. History of Abnormal pap	☐	☐
Treatment ____________________		
16. Date of last mammogram ____________		
17. Age of onset of periods ____________		
18. Frequency of periods ____________		

FEMALES ONLY *(continued)*

19. Last menstrual period ____________________
20. Pregnancies ____________________
21. Live births ____________________
22. Miscarriages / abortions ____________________
23. Other ____________________

MUSCULOSKELETAL	Yes	No
1. Joint pain / tenderness	☐	☐
2. Joint swelling / warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back / neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other ____________________		

SKIN	Yes	No
1. Rashes	☐	☐
2. Dry / itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole / lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair/nail problems	☐	☐
9. Other ____________________		

NEUROLOGIC	Yes	No
1. Headaches / migraines	☐	☐
2. Dizziness / nausea	☐	☐
3. Fainting / blackouts	☐	☐
4. Numbness / tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures / convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other ____________________		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. overly emotional / mood swings	☐	☐
6. Hallucinations	☐	☐
7. Phobias	☐	☐
8. Other ____________________		

CARDIOVASCULAR	Yes	No
1. Heart attack/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/Murmur	☐	☐
8. Other ____________________		

URINARY	Yes	No
1. Pain / burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other ____________________		