Patient Medical History

Name: _____ Date of Birth : _____

Person Completing Form: _____ Relationship: _____ Date _____

List Any Specialist You See : _____

_____

Date of last physical exam : _____ Performed By : _____

Occupation : _____ Marital Status : _____

List Any Allergies To Medications : N/A [ ] Allergy to Latex : Y [ ] N [ ]

Medication Allergy	Reaction

Please List All Medications : N/A [ ]

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Please List Any Surgeries You Have Had : N/A [ ]

Surgery	Date

Surgery	Date

Health Maintenance

Date of :	Date of :
Last Pap test	Last Eye Exam
Last Mammogram	Last Colonoscopy
Last Dental Exam	Last Bone Scan

Vaccinations :

Please circle Tetanus: When _____ Flu: When _____ Pneumonia: When _____ Other _____

PATIENT NAME : _____ **Date :** _____

PULMONARY PROBLEMS No [ ] If Yes, Circle

COPD/Emphysema
Asthma
Pneumonia
Tuberculosis
Pulmonary Embolism
Use of O2 _____
Sleep Apnea
Short of Breath at Rest/Exertion

History of fever, night sweats, cough, fatigue, Sputum>3 weeks Y [ ] N [ ]

Other_____

CPAP Machine

Settings of CPAP/BIPAP Machine :_____

CARDIAC PROBLEMS No [ ] If Yes, Circle

Congestive Heart Failure
High Blood Pressure
High Cholesterol
Angina/Chest Pain
Coronary Heart Disease
Endocarditis
Rheumatic Fever
Cardiac Catherization Date __
Heart Valve Problems
Heart Murmur
Heart Attack: When _____
Peripheral Vascular Disease
Cardiomyopathy
Irregular Heartbeat

DVT (Deep Vein Thrombosis)

Pacemaker When_____ Type _____

Defibrillator When _____ Type _____

EYE, EAR, NOSE, THROAT PROBLEMS No [ ] If Yes, Circle

Cataracts
Photophobia
Macular Degeneration
Legally Blind
Hearing Aids
Peripheral Vision Problems
Glasses
Contact Lenses
Prosthesis
Dentures

Enucleation L[ ] R [ ]
Glaucoma L [ ] R [ ]
Hearing Loss L [ ] R [ ]
TMJ
Allergies

Other Problems _____

GENITOURINARY PROBLEMS No [ ] If Yes, Circle

Kidney Stones
Urinary Tract Infections
Prostate Problems
Dialysis Days _____ (Peritoneal or Hemodialysis)

Other Problems _____

GASTROINTESTINAL PROBLEMS No [ ] If Yes, Circle

Hepatitis: Type _____
Liver Disease
Heartburn
Peptic Ulcer
Hiatal Hernia
Pancreatitis
Gall Bladder
Irritable Bowel/Crohn's

NEUROLOGICAL PROBLEMS No [ ] If Yes, Circle

CVA/Stroke
Transient Ischemic (TIA)
Dementia/Alzheimer's
Parkinson's
Multiple Sclerosis
Peripheral Neuropathy
Lyme Disease
Seizures/Epilepsy
Head Trauma
Dizziness/Vertigo
Fainting
Headaches
Other _____

MUSCULOSKELETAL PROBLEMS No [ ] If Yes, Circle

Arthritis
Disk Disease
Osteoporosis
Gout
Chronic Fatigue
Muscle Weakness
Fibromyalgia
Back Injury
Unsteady Gait
Limited Movement
Neck Pain

CANCER HISTORY No [ ] If Yes, Circle

Cancer Type _____

SYSTEM PROBLEMS

Female Reproductive Problems
Post Menopausal LMP_____

HEMATOLOGIC PROBLEMS No [ ] If Yes, Circle

Anemia
Clotting Problems

ENDOCRINE PROBLEMS No [ ] If Yes, Circle

Hypothyroidism Hyperthyroidism
Diabetes: Type _____ Insulin [ ] Non-Insulin [ ]

PSYCHOSOCIAL HISTORY No [ ] If Yes, Circle

Do you smoke? Y[ ] N[ ] PPD_____

Exposure to second hand smoke? Y [ ] N [ ]

Other tobacco use: _____

Alcohol Use: How Much _____

Substance Use: _____

Do you feel your alcohol/Substance Use is a problem? Y [ ] N [ ]

Depression Panic/Anxiety Attacks

Other Psychiatric Problems _____

AUTOIMMUNE DISEASES No [ ] If Yes, Circle

Lupus Sjogrens
Other _____

COMMUNICABLE DISEASES No [ ] If Yes, Circle

HIV VRE
MRSA

PATIENT NAME : _____ **Date :** _____

Family History

Diabetes	Y[ ]	N[ ]	if yes, _____
Stroke	Y[ ]	N[ ]	if yes, _____
Seizure	Y[ ]	N[ ]	if yes, _____
Kidney	Y[ ]	N[ ]	if yes, _____
Liver	Y[ ]	N[ ]	if yes, _____
Breast Cancer	Y[ ]	N[ ]	if yes, _____
Colon Cancer	Y[ ]	N[ ]	if yes, _____
Prostate Cancer	Y[ ]	N[ ]	if yes, _____
Cardiac	Y[ ]	N[ ]	if yes, _____

Other Problems

_____

_____

_____