PATIENT CONFIDENTIAL MEDICAL HISTORY

NAME _____TODAY'S DATE _____ WT:_____HT:_____

WHY DO YOU NEED TO SEE THE DOCTOR? _____

DATE YOUR PROBLEM BEGAN _____ HOW DID IT START? (gradual)(sudden) (accident)

GIVE DETAILS _____

LOCATION IF ACCIDENT_____

NAME PROVIDERS YOU HAVE SEEN ABOUT YOUR PROBLEM _____

LIST ANY TREATMENT TO DATE_____

WHEN ARE YOUR SYMPTOMS? (night)(morning)(afternoon)(evening)(work)(sports)

HOW SEVERE (mild) (moderate) (severe)

PAST LIFETIME MEDICAL HISTORY OF PATIENT

DIABETES: How long? _____

CANCER: Site_____ When discovered? _____

HEART ATTACK: When _____

STROKE: When _____

COPD/Emphysema: Oxygen at home? _____

BIPOLAR DEPRESSION

KIDNEY FAILURE: are you on dialysis? _____

SLEEP APNEA: Do you use C-PAP? _____

LIST ANY DETAILS OF ABOVE:

_____

_____

MEDICATIONS & DOSES: (INCLUDE ALL MEDICATIONS THAT YOU HAVE TAKEN IN PAST 3 MONTHS OF ANY SORT INCLUDE VITAMES AND OVER THE COUNTER MEDICATIONS AND ANY NERVE MEDICATIONS OR FOR PAIN)

_____

_____

_____

_____

_____

_____

_____

_____

LIST ANY DRUG ALLERGY OR REACTIONS_____

LIST ANY SURGERY YOU HAVE HAD IN YOUR ENTIRE LIFE TO ANY PART OF YOUR BODY. IF ABLE, INDICATE WHEN IT WAS DONE

_____

_____

_____

_____

HAVE YOU APPLIED OR ARE CONSIDERING APPLYING FOR (SOCIAL SECURITY DISABILITY) (WORKER'S COMPENSATION) (LAW SUIT)
DETAILS _____

REVIEW OF BODY SYSTEMS – past 6 months – check at least "No problem"

Constitutional
- ☐ No problem
- ☐ Major illness recently
- ☐ Fevers
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats

Neurological
- ☐ No problem
- ☐ Numbness: where _____
- ☐ Muscle Weakness
- ☐ Ever a seizure
- ☐ Dizziness
- ☐ Poor Balance or falls
- ☐ Stroke or TIA
- ☐ Other _____

Eyes
- ☐ No Problem
- ☐ Poor vision
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Had surgery

Ears/Nose/Throat/Mouth
- ☐ No problem
- ☐ Hearing Loss
- ☐ Dentures
- ☐ Decayed teeth
- ☐ Vertigo
- ☐ Sore throat

Cardiovascular
- ☐ No problem
- ☐ Chest pain
- ☐ Heart attack
- ☐ Heart stint
- ☐ Leg or aorta stints
- ☐ Poor circulation
- ☐ Heart Palpitations (skip beat)
- ☐ High blood pressure
- ☐ Heart valve or muscle disease
- ☐ Short of breath on stairs
- ☐ Swelling ankles/feet
- ☐ Blood clot: Where _____

Respiratory
- ☐ No problem
- ☐ Wheezing/Asthma
- ☐ Recent cold/flu
- ☐ Coughing up blood

Gastrointestinal
- ☐ No problem
- ☐ Heartburn or reflux
- ☐ Stomach ulcer
- ☐ Black/blood stools
- ☐ Liver disease/Hepatitis
- ☐ Other

Genitourinary
- ☐ No problem
- ☐ Painful urination
- ☐ Urgency to Urinate
- ☐ Blood in urine
- ☐ Poor urine flow
- ☐ Frequent infections
- ☐ Kidney disease
- ☐ Pregnant
- ☐ Last Menstrual period _____

Musculoskeletal
- ☐ None but present illness
- ☐ Fractures
- ☐ Joint pain/swelling
- ☐ Gout
- ☐ Arthritis: type _____
- ☐ Fibromyalgia
- ☐ Other arm/leg pain other than Present illness: Location _____

Skin
- ☐ No problem
- ☐ Psoriasis
- ☐ Rashes
- ☐ Skin sores slow to heal

Hematological
- ☐ No problems
- ☐ Low blood/anemia
- ☐ Lymph nodes
- ☐ Bleed/bruise easily
- ☐ Had transfusions

Psychiatric
- ☐ None known
- ☐ Depression
- ☐ Anxiety
- ☐ Attention deficit or hyperactivity disorder

Allergy/Immunologic
- ☐ No problem
- ☐ Poor healing wounds
- ☐ Persistent infection
- ☐ Exposure to HIV or Hepatitis

Endocrine
- ☐ No problem
- ☐ Thyroid disease
- ☐ Diabetes
  On Insulin? _____
  Latest A1c _____

Any other health issues?
_____
_____
_____

SOCIAL HISTORY

SMOKE? (YES) (NO) (FORMERLY) _____PACKS PER DAY _____ (SNUFF) (CIGARS) (PATCHES)

ALCOHOL (NEVER) (SOCIAL) (WEEKENDS) (DAILY) _____EVER HAD ADDICTION TREATMENT? (YES) (NO) WHEN _____

DO YOU LIVE ALONE? (YES) (LIST OTHERS) _____

YOUR CHILDREN'S AGES _____

HOBBIES OR SPORTS _____ ARE YOU ON A SPORTS TEAM? _____

FAMILY HISTORY

LIST ILLNESSES IN YOUR FAMILY _____

MOTHER'S ILLNESSES (ALIVE) (DECEASED)_____

FATHER'S ILLNESSES (ALIVE) (DECEASED) _____

LIST ANY ANESTHESIA COMPLICATIONS IN YOUR FAMILY _____

LIST ANY BLEEDING DISORDERS IN YOUR FAMILY _____