Confidential Medical History Form

Please bring these completed forms to your office appointment

Name: _____ Birth date: _____

What is your reason for visit?_____

Symptoms Check symptoms you currently have or have had in the past 6 months

General
- □ Weight Loss
- □ Weight Gain
- □ Fatigue, Weakness
- □ Night Sweats
- □ Fevers

Muscular Skeletal
- □ Muscle Cramp/Pain
- □ Pain in Joints
- □ Neck Pain
- □ Back Pain

Respiratory
- □ Cough
- □ Wheezing
- □ Trouble Breathing
- □ Bloody Sputum
- □ Pain on Breathing

Gastrointestinal
- □ Poor Appetite
- □ Heart Burn
- □ Abdominal Pain
- □ Nausea
- □ Vomiting
- □ Black Tarry Stool
- □ Constipation
- □ Diarrhea
- □ Bowel Changes

Urinary
- □ Blood in Urine
- □ Frequent Urination
- □ Loss of Urine
- □ Painful Urination
- □ Night Time Urination

Cardiovascular
- □ Chest Pain
- □ Heart Racing
- □ Leg Swelling
- □ Irregular Heartbeat
- □ Rapid Heartbeat
- □ Poor Circulation
- □ Swelling of Ankles
- □ Varicose Veins

Skin
- □ Easy Bruising
- □ Hives
- □ Itching
- □ Change in Moles
- □ Rash
- □ Dry Skin
- □ Sore That Won't Heal

Ear, Nose, Throat
- □ Bleeding Gums
- □ Blurred Vision
- □ Visual Changes
- □ Hearing Loss
- □ Nose Bleeds
- □ Hoarseness
- □ Sinus Problems

Neuro/Psych
- □ Headaches
- □ Dizziness
- □ Depression
- □ Forgetfulness
- □ Anxiety

Men Only
- □ Breast Lump
- □ Erection Difficulties

Conditions Check conditions you currently have or have had in the past.

- □ Alcoholism
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Depression
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Gout
- □ Heartburn
- □ Heart Disease
- □ Headaches
- □ Hepatitis
- □ Herpes
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV/AIDS
- □ Kidney Disease
- □ Lung Disease
- □ Liver Disease
- □ Migraine
- □ Mononucleosis
- □ Pneumonia
- □ Prostate Problem
- □ Rheumatic Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers

What Specialists do you see? _____

Women Only

Date of last period? _____
How many days do your periods Last? _____
Are they: Painful? _____ Heavy?_____ Irregular? _____
How many days between periods? _____
Do you have pain with intercourse?_____
What type of birth control are you using? (include tubal ligation or vasectomy) _____
Last Pap Smear? _____ Last Mammogram?_____
Do you have a history of abnormal pap smears? _____
When and what treatment was given?_____
Have you ever had PID, Chlamydia, Herpes, Condyloma (genital warts), or any other sexually transmitted diseases? _____

Pregnancy History:

No. of Pregnancies? _____ Premature Births? _____ Miscarriages? _____
Abortions? _____ Tubal Pregnancies? _____ C-Sections? _____
Living Children?_____
Any complications during pregnancies or labor and delivery? Y or N

Previous Hospitalizations and Surgeries

Year	Hospital	Reason for Hospitalization

Medications: List medications you are currently taking. Name, Dosage, Frequency	***Allergies:*** to medications or substances	***Supplements/Vitamins:*** (Include Calcium)

Do you smoke cigarettes? Y or N How many per packs per day? _____ How many years? _____
Do you drink alcohol? Y or N How often/How many per week? _____

Do you use any "recreational drugs"? Please list:_____

Family History: Fill in Health information about your family

Relationship	Age	Medical Condition*	Age at Death	Cause of Death
Father				
Mother				
Brother				
Sister				
Children (sex)				
Dad's Dad				
Dad's Mom				
Mom's Dad				
Mom's Mom				

***Like diabetes, high blood pressure, arthritis, cancer (type of), kidney disease, depression, chemical dependency.**