Patient Medical History

Patient Name: ________________________________ I prefer to be called: ______________________________

Date of Birth: ______________________ I identify myself as: ❍Female ❍Male ❍Other

HEALTH LITERACY

Do you need an interpreter? ❍Yes ❍No

Do you have any barriers to learning?

❍ No barriers	❍ Visual	❍ Emotional	❍ Cultural
❍ Reading	❍ Hearing	❍ Cognitive	❍ Spiritual
❍ Language	❍ Physical	❍ Financial	❍ Other: ____________

What is your learning preference?
❍ Listening ❍ Reading ❍ Demonstration ❍ Pictures ❍ Other: ________________

Does someone assist you with your medications, help you with forms, or take you to appointments? ❍Yes ❍No

REVIEW OF SYMPTOMS

CONSTITUTIONAL SYMPTOMS

- Good general health lately ❍ Yes ❍No
- Fatigue/tired ❍ Yes ❍No
- Weight loss ❍ Yes ❍No
- Weight gain ❍ Yes ❍No
- Fever/chills/night sweats ❍ Yes ❍No

EYES

- Eye disease or injury ❍ Yes ❍No
- Glaucoma/cataracts ❍ Yes ❍No
- Wears glasses/contact lenses ❍ Yes ❍No

EARS/NOSE/THROAT

- Hearing loss or ringing ❍ Yes ❍No
- Chronic sinus problems ❍ Yes ❍No
- Sore throat or voice change ❍ Yes ❍No

CARDIOVASCULAR

- Chest pain ❍ Yes ❍No
- Shortness of breath with walking or lying flat ❍ Yes ❍No

RESPIRATORY

- Chronic or frequent coughs ❍ Yes ❍No
- Shortness of breath ❍ Yes ❍No
- Asthma or wheezing ❍ Yes ❍No

GASTROINTESTINAL

- Heartburn ❍ Yes ❍No
- Vomiting blood ❍ Yes ❍No
- Loss of appetite ❍ Yes ❍No
- Change in bowel movements ❍ Yes ❍No
- Frequent diarrhea ❍ Yes ❍No
- Painful bowel movements or constipation ❍ Yes ❍No
- Rectal bleeding or blood in stool ❍ Yes ❍No
- Abdominal pain ❍ Yes ❍No

GENITOURINARY

- Frequent urination ❍ Yes ❍No
- Burning or painful urination ❍ Yes ❍No
- Lose control of bladder ❍ Yes ❍No
- Awaken at night to urinate (more than twice) ❍ Yes ❍No
- Blood in urine ❍ Yes ❍No
- Sexual concerns ❍ Yes ❍No
- Sexually active ❍ Yes ❍No
  - If yes, my partner(s) are ❍ Male ❍Female

FEMALES ONLY – GYNECOLOGICAL

- Vaginal discharge ❍ Yes ❍No
- Abnormal vaginal bleeding ❍ Yes ❍No
- Last menstrual period: ______________
- Do you use birth control? ❍ Yes ❍No
  - If yes, type: ____________________

MALES ONLY – GENITOURINARY

- Discharge from penis ❍ Yes ❍No
- Difficulty getting an erection ❍ Yes ❍No

MUSCULOSKELETAL

- Joint pain, stiffness or swelling ❍ Yes ❍No
- Weakness of muscles ❍ Yes ❍No
- Back pain ❍ Yes ❍No
- Difficulty in walking ❍ Yes ❍No

INTEGUMENTARY (SKIN, BREAST)

- Changing moles ❍ Yes ❍No
- Varicose veins ❍ Yes ❍No
- Breast pain ❍ Yes ❍No
- Breast lump ❍ Yes ❍No
- Breast discharge ❍ Yes ❍No

NEUROLOGICAL

- Frequent or recurring headaches ❍ Yes ❍No
- Numbness or tingling sensations ❍ Yes ❍No

MENTAL HEALTH

- Depression ❍ Yes ❍No
- Anxiety ❍ Yes ❍No
- Other mental health concerns ❍ Yes ❍No
  - If yes, type: ____________________

ENDOCRINE

- Do you have excessive thirst? ❍ Yes ❍No
- Thyroid disease ❍ Yes ❍No
- Heat/cold intolerance ❍ Yes ❍No

HEMATOLOGICAL/LYMPHATIC

- Bleeding or bruising tendency ❍ Yes ❍No
- Blood clots ❍ Yes ❍No
- Enlarged glands/lymph nodes ❍ Yes ❍No

SLEEP HABITS

- Do you have sleep concerns? ❍ Yes ❍No
- Do you snore? ❍ Yes ❍No
- How many hours of sleep per night: _____

(Continued on back)

SOCIAL HISTORY

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Separated ❍ Widowed ❍ Partnered

Number of children: ______ Occupation: ______________________________

HABITS

	Yes	No	
Do you smoke?............	❍	❍	How many packs/day? ___ How many years? ___
Do you want to quit?............	❍	❍	
Do you drink alcohol?............	❍	❍	If yes, how many drinks in the average week? ___
Do you use street drugs?............	❍	❍	What type? __________ How many years? ___
Do you drink caffeine?	❍	❍	How much per day? ________________
Do you exercise?	❍	❍	Number of days per week? ________________
Do you follow any specific diet?............	❍	❍	Please specify: ________________
Do you have concerns with access to food?	❍	❍	

SAFETY

	Yes	No
Do you feel safe in your relationship?............	❍	❍
Do you wear your seatbelt?	❍	❍
Are there guns in your home?............	❍	❍
If yes, are they stored properly?	❍	❍
Does your home have working smoke alarms?............	❍	❍
Does your home have working carbon monoxide detectors?......	❍	❍

*****Complete the following only if there are changes since your last visit*****

MEDICAL PROBLEMS – complete only if changed since your last visit

❍ None

❍ Allergies
❍ Anxiety
❍ Asthma, wheezing
❍ Bladder/kidney problems
❍ Cancer, type: ________________
❍ Depression
❍ Diabetes
❍ Glaucoma
❍ Heart problems
❍ Hepatitis
❍ High blood pressure
❍ Osteoporosis
❍ Pneumonia/pleurisy
❍ Stroke
❍ Thyroid disease
❍ Other:

____

____

MEDICATION ALLERGIES – complete only if changed since your last visit

Allergies to Medications

❍ NONE

Allergies to Latex? ❍ Yes ❍ No

List Medication Allergies	Reaction

PREVIOUS OPERATIONS/SURGERIES – complete only if changed since your last visit

❍ NONE ❍ Complete below if changes since last seen here

Type of Surgery	Type of Surgery

FAMILY HISTORY (check all that apply) – complete only if changed since your last visit

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Status (A=alive/D=deceased)								
No known problems								
Alcoholism								
Anesthesia problems								
Bleeding problems								
Cancer, type:								
Diabetes								
Drug addiction								
Heart disease or heart attack								
High blood pressure								
High cholesterol								
Mental health concerns								
Stroke								
Thyroid disease								
Other:								