Patient Past & Present Medical History
PLEASE FILL OUT ENTIRE FORM

Patient Name: ____

Reason for Visit/Current Symptoms:

____

____

Surgery: (List any major operations you have had)

Year	**Type of Operation**	**Please list any Complications**
________	___________________________________	___________________________________
________	___________________________________	___________________________________
________	___________________________________	___________________________________

Last Colonoscopy: ________________________ **Last Endoscopy:** ___________________________

Hospitalizations:

Year	**Reason you were hospitalized**
________	____
________	____
________	____

Medications & Any over the Counter Meds: (List any drugs that you take regularly with doses and frequency)

Medication Name:	**Dosage / Miligrams**	**How Often:**
____________________________________	___________________	________________________
____________________________________	___________________	________________________
____________________________________	___________________	________________________
____________________________________	___________________	________________________
____________________________________	___________________	________________________

Medication Allergies? YES NO
If yes, please list____

Social History: **(Check items which apply ONLY to the patient)**

Tobacco: ___ Yes ___ No
If Yes, How Many Packs per Day? ____
Age Started ________
When Stopped: ____________________

Alcohol: ___ Yes or ___ No
If Yes, How Many Per Occasion? ____
How many per week? __________

***IF PATIENT IS A MINOR, WHO DO THEY LIVE WITH?** ____

FAMILY HISTORY:
Mother Date of Birth: ___/___/___ Living / Dead @ Age__________ List Health Problem(s) ____________________
Father Date of Birth: ___/___/___ Living / Dead @ Age__________ List Health Problem(s) ____________________

Check if Mom/Dad/Siblings has ever had, please use checkmark with M – Mom, D-Dad and S-Sibling:

Breast Cancer	____	Ovarian Cancer	____	Diabetes	____
Lung Cancer	____	Stomach Cancer	____	Stroke	____
Colon Cancer	____	Brain Cancer	____		
Prostate Cancer	____	Heart Disease	____	Inherited Conditions:	________________________

****Please Only Check What Pertains to the Patient****

Constitutional
- Weight Gain/Loss __
- Fever __
- Fatigue __
- Chills __
- Dizziness __
- Cancer __

Dermatology
- Skin Cancers __
- Recurrent Rashes __
- Lump or Bumps __
- Atypical Moles __

HEENT
- Loss of Hearing __
- Cataracts __
- Tonsillitis __
- Difficulty Swallowing __
- Ear Infections __
- Glaucoma __
- Frequent Nosebleeds __
- Corrective Lenses __
- Dentures __
- Ringing in Ears __

Pulmonary
- Pneumonia __
- Chronic Sputum __
- Bronchitis __
- Asthma __
- Emphysema __
- Tuberculosis __
- Chronic Cough __
- Pleurisy __
- COPD __
- Trouble Breathing __
- Smoker __

Cardiovascular
- High Cholesterol __
- High Blood Pressure __
- Heart Valve Disease __
- Heart Failure __
- Shortness of Breath __
- Angina (chest pain) __
- Mitral Valve Prolapse __
- Varicose Veins __
- Palpitations (heart racing) __
- Leg pain with Walking __
- Atrial Fibrillation __
- Heart Attack (MI) __
- Stents __
- Coronary Artery Bypass Graft __

Gastrointestinal
- Gastritis Peptic Ulcer Disease __
- Blood in Stool or Vomitus __
- Change in Bowel Habits __
- Hemorrhoids __
- Diverticulosis __
- Hiatal Hernia __
- Hepatitis __
- Loss of Appetite __
- Diarrhea __
- Tar like Stools __
- Reflux __
- Crohn's Disease __
- Gas Pain __
- Constipation __
- Change in Stools __
- Gallstones __
- Colitis __
- Nausea __
- Vomiting __

Urinary
- Kidney Stone __
- Prostate Trouble __
- Kidney or Bladder Infections __
- Difficulty Voiding __
- Blood in Urine __

Musculoskeletal
- Arthritis __
- Back Pain __
- Ankle Swelling __
- Limitation of Range __
- Limitation of Motion __

Neuro
- Stroke __
- TIA __
- Seizure __
- Migraines __

Psych
- Depression __
- Mental Illness __

Hematology
- HIV/AIDS __
- Bleeding __

- Received Blood __
- Received Plasma __

Date Received ______________

- Blood Disorder __
- Clotting Disorder __
- Pulmonary Embolism __
- Deep Vein Thrombosis __

Endocrine
- Diabetes (Insulin/Non Insulin) __
- Heat or Cold Tolerance __
- Thyroid Problems __
- Loss of Hair __
- Goiter __
- Change in Voice __

Anesthesia
- Reactions __
- Nausea __
- Vomiting __

*Please list any other medical conditions: ____

PATIENTS 6 MONTHS AND OLDER: HAVE YOU HAD A FLU SHOT THIS SEASON? YES NO

PATIENTS 65 YEARS AND OLDER: HAVE YOU HAD A PNEUMONIA SHOT? YES NO