

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Case No.	Medicare No.	Medicaid No.	Today's Date	Birth date	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Last Name		First	Middle	Daytime phone		Home Phone
Address			City	State	Zip	Marital Status
Person to notify in emergency			Daytime Phone		Relationship	
By Doctor			Phone		Family or Referring Doctor	
May I contact either of these Doctors for your past health records?			Yes <input type="checkbox"/> No <input type="checkbox"/>		What are your present medical symptoms?	
			Last Physical Examination Date			
			Phone No.			

Family History	IF LIVING			IF DECEASED		Any blood relatives who have or have had any of the listed conditions							
	Age	Good	Fair	Death Age	Death Cause	✓ Yes No Relationship			✓ Yes No Relationship				
Father						Asthma				Hay Fever			
Mother						Arthritis				Insanity			
Brothers (Circle Sisters Sex)						Allergies				Kidney Disease			
1. M F						Anemia				Leukemia			
2. M F						Alcoholism				Migraine			
3. M F						Bleeding Tend.				Nervous Break'n			
4. M F						Cancer				Obesity			
5. M F						Colitis				Rheumatism			
Husband <input type="checkbox"/> Wife <input type="checkbox"/>						Congenital Heart				Rheumatic Fever			
Sons (circle Daughters sex)						Diabetes				Stroke			
1. M F						Epilepsy				Suicide			
2. M F						Goiter				Stomach Ulcers			
3. M F						High Bl. Press.				Tuberculosis			
4. M F						Heart Disease							
5. M F													
6. M F													

HABITS	MEDICATIONS	Other
Do You ✓ Yes No Smoke <input type="checkbox"/> <input type="checkbox"/> Drink Coffee <input type="checkbox"/> <input type="checkbox"/> Drink Alcohol <input type="checkbox"/> <input type="checkbox"/> Drink Beer <input type="checkbox"/> <input type="checkbox"/> Fall Asleep Easily <input type="checkbox"/> <input type="checkbox"/> Awaken Early <input type="checkbox"/> <input type="checkbox"/>	Daily Consumption: _____ Pkgs. _____ Cups _____ oz. _____ oz.	✓ If Taken Blood Thinning Pills <input type="checkbox"/> Iron or Poor Blood Med. <input type="checkbox"/> Vitamins <input type="checkbox"/> Antacids <input type="checkbox"/> Cortisone <input type="checkbox"/> Laxatives <input type="checkbox"/> Water Pills <input type="checkbox"/> Antibiotics <input type="checkbox"/> Cough Medicine <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Weight Reducing Pills <input type="checkbox"/> Aspirin, Bufferin, Anacin <input type="checkbox"/> Digitalis <input type="checkbox"/> Shots <input type="checkbox"/> Other (list) _____ Barbiturates <input type="checkbox"/> Dilantin <input type="checkbox"/> Sleeping Pills <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Hormones <input type="checkbox"/> Thyroid Med. <input type="checkbox"/> Blood Pressure Pills <input type="checkbox"/> Insulin, Diabetic Pills <input type="checkbox"/> Tranquilizers <input type="checkbox"/>

Operations you have had:	Diseases you have had requiring hospitalization	Serious illness not requiring hospitalization
Year	Year	Year
_____	_____	_____
_____	_____	_____

Drugs you are allergic to: _____ _____	Describe any serious injuries or accidents you have had _____ _____
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WOMEN only: ✓ Yes No

Are you still having regular monthly menstrual periods?

Have you ever had bleeding between your periods? When? _____

Do you have very heavy bleeding with your periods? When? _____

Do you feel bloated and irritable before your period?

Are you now on or have you ever taken the birth control pill? When? _____

Have you ever had a miscarriage? When? _____

Have you ever had a discharge from the nipple of your breast? When? _____

Do you regularly have the cancer test of the cervix? Date of last test _____

How many children born alive _____

How many stillbirths _____

How many premature births _____

Date of last menstrual period _____

How many miscarriages _____

How many cesarean operations _____

Any complications of pregnancy? (explain) _____

MEN only: Have you ever had: ✓ Yes No

Loss of sexual activity? For how long?

Treatment for genitals (private parts)?

Discharge from penis?

Hernia (rupture)?

Prostate trouble?

MEN and WOMEN:

- Do you frequently have severe headaches
- (If yes, answer the following):
- Do they cause visual trouble?
- Do they occur on one side of the head?
- Do they awaken you at night?
- Do they feel like a tight hat band?
- Do they hurt most in the back of the head and neck?
- Does aspirin relieve them?

- Have you recently had pain in the stomach which:**
- Occurs 1-2 hours after a meal?
 - Is brought on by eating fried foods, gassy foods?
 - Awakens you at night?
 - Is relieved by antacid medications?
 - Is relieved with milk or eating?
 - Occurs while eating or immediately after?
 - Is relieved by a bowel movement?
 - Causes loss of appetite?

- Have you ever fainted?
- Spells of dizziness?
- Spells of weakness of arm or leg?
- Ringing in ears?
- Have you ever had a convulsion?
- Double vision?
- Pains in ear?
- Nosebleeds?

- Do you frequently have:**
- Bleeding gums?
 - Trouble swallowing?
 - Hoarseness?
 - A sore tongue?
 - Nausea and vomiting?

- Have you ever had shortness of breath?**
- Doing your usual work?
 - Climbing a flight of stairs?
 - Which awakens you at night?
 - Do you have a chronic cough?
 - Which causes you to cough?
 - Accompanied by wheezing?
 - Have you ever coughed blood?
 - Do you cough up much sputum?

- Have you had pain or tightness in the chest which begins:**
- When exerting yourself?
 - When walking against a wind?
 - When walking up a hill?
 - After a heavy meal?
 - When upset or excited?
 - Palpitations
 - Do you sleep on more than one pillow?

- Radiates down the arm?
 - Disappears if you rest?
 - Occurs only at rest?
 - When walking fast?
 - When walking in cold weather?
- If you have chest pain or tightness please explain.....

- Have you had?**
- | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When or since when? |
|------------------------------|-----------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |

- Have you recently had:**
- | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When or since when? |
|------------------------------|-----------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |

- If you have had a change in bowel habit recently answer the following:**
- | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When or since when? |
|------------------------------|-----------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Describe briefly your present medical symptoms and anything else we should know about your health.
