SS # _____

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 ☐ Female ☐
Last Name First Middle			Daytime phone	Home Phone	
Address City State Zip			Marital Status	Occupation	
Person to notify in emergency	Daytime Phone		Relationship	Last Physical Examination Date	
By Doctor	Phone		Family or Referring Doctor	Phone No.	
May I contact either of these Doctors for your past health records? Yes ☐ No ☐	What are your present medical symptoms?				

Family History	IF LIVING Age	IF LIVING HEALTH Good Fair Poor	IF DECEASED Death Age	IF DECEASED Death Cause
Father				
Mother				
Brothers (Circle Sisters Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Sons (circle Daughters sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Any blood relatives who have or have had any of the listed conditions

	✔ Yes	No	Relationship		✔ Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Insanity			
Allergies				Kidney Disease			
Anemia				Leukemia			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Break'n			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease							

HABITS

Do You	✔ Yes	No	Daily Consumption:
Smoke	☐	☐	_____ Pkgs.
Drink Coffee	☐	☐	_____ Cups
Drink Alcohol	☐	☐	_____ oz.
Drink Beer	☐	☐	_____ oz.
Fall Asleep Easily	☐	☐	
Awaken Early	☐	☐	

MEDICATIONS

✔ If Taken	✔	✔	✔
Antacids	☐	Blood Thinning Pills ☐	Iron or Poor Blood Med. ☐	Vitamins ☐
Antibiotics	☐	Cortisone ☐	Laxatives ☐	Water Pills ☐
Aspirin, Bufferin, Anacin	☐	Cough Medicine ☐	Phenobarbital ☐	Weight Reducing Pills ☐
Barbiturates	☐	Digitalis ☐	Shots ☐	Other (list) _____
Birth Control Pills	☐	Dilantin ☐	Sleeping Pills ☐	
Blood Pressure Pills	☐	Hormones ☐	Thyroid Med. ☐	
		Insulin, Diabetic Pills ☐	Tranquilizers ☐	

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

Drugs you are allergic to:

Describe any serious injuries or accidents you have had

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:

	✔ Yes	No
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:

	✔ Yes	No
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?	☐	☐

	✔ Yes	No		✔ Yes	No
Have you ever fainted?	☐	☐	Have you ever had a convulsion?	☐	☐
Spells of dizziness?	☐	☐	Double vision?	☐	☐
Spells of weakness of arm or leg?	☐	☐	Pains in ear?	☐	☐
Ringing in ears?	☐	☐	Nosebleeds?	☐	☐

Do you frequently have:

	✔ Yes	No		✔ Yes	No
Bleeding gums?	☐	☐	A sore tongue?	☐	☐
Trouble swallowing?	☐	☐	Nausea and vomiting?	☐	☐
Hoarseness?	☐	☐			

Have you ever had shortness of breath?

	✔ Yes	No
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:

	✔ Yes	No
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?	☐	☐

	✔ Yes	No
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?	✔ Yes	No	**When or since when?**
Burning when urinating?	☐	☐	_____
Loss of control of bladder?	☐	☐	_____
Blood in the urine?	☐	☐	_____
Dark colored urine?	☐	☐	_____
Trouble starting to urinate?	☐	☐	_____
Trouble holding the urine?	☐	☐	_____
To get up frequently at night?	☐	☐	_____
Passed a kidney stone?	☐	☐	_____

Have you recently had:	✔ Yes	No	**When or since when?**
Pains in calves of legs when walking?	☐	☐	_____
Cramps in legs at night?	☐	☐	_____
Pain in the big toe?	☐	☐	_____
Varicose veins?	☐	☐	_____
Phlebitis or inflamed leg veins?	☐	☐	_____
Swelling in the ankles	☐	☐	_____

If you have had a change in bowel habit recently answer the following:	✔ Yes	No	**When or since when?**
Crampy pain in abdomen?	☐	☐	_____
Alternating diarrhea and constipation?	☐	☐	_____
Pain during or after bowel movement?	☐	☐	_____
Mucous in the stool?	☐	☐	_____
Blood in the stool?	☐	☐	_____
Ribbon like stools?	☐	☐	_____
Black stools?	☐	☐	_____
Require use of strong laxatives or enemas?	☐	☐	_____
_____	☐	☐	_____

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

_____

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