Name:
DOB:
Chart:
Age:
Date:

MEDICAL HISTORY

Patient Name: ____________________

Age: __________ Sex: __________ Height: __________ Weight: __________

Date of Birth: ____________________

Your Occupation: ____________________

Past Medical History ☐ I have NO MEDICAL HISTORY

GENERAL			GASTROINTESTINAL			RESPIRATORY		
Weight Change	YES	NO	Difficulty Swallowing	YES	NO	Pneumonia	YES	NO
Fever or Chills	YES	NO	Ulcer	YES	NO	Tuberculosis	YES	NO
Night Sweats	YES	NO	Hepatitis ________	YES	NO	Pulmonary Embolism	YES	NO
Bleeding	YES	NO	Reflux	YES	NO	Asthma	YES	NO
Lumps or Masses	YES	NO	CARDIOVASCULAR			Emphysema	YES	NO
Dizziness or Fainting	YES	NO	Myocardial Infarction	YES	NO	COPD	YES	NO
Cancer: ________	YES	NO	Cholesterol	YES	NO	Sleep Apnea	YES	NO
EYE-EAR-NOSE-THROAT			High Blood Pressure	YES	NO	GENITOURINARY		
Visual Loss	YES	NO	Artrial Fibrillation	YES	NO	Urinary Infection	YES	NO
Hearing Loss	YES	NO	Peripheral Arterial Disease	YES	NO	Venereal Disease	YES	NO
Ringing in Ears	YES	NO	Heart Failure	YES	NO	Menopause	YES	NO
Macular Degeneration	YES	NO	Mitral Valve Prolapse	YES	NO	Kidney/Renal Disease	YES	NO
Glaucoma	YES	NO	Blood Clots	YES	NO	Dialysis	YES	NO
MUSCULOSKELETAL			Stents	YES	NO	CANCER		
Osteoarthritis	YES	NO	Pacemaker	YES	NO	Type: ________		
Gout	YES	NO	Defibrillator	YES	NO	PSYCHOLOGICAL		
Osteoporosis	YES	NO	NEUROLOGICAL			Anxiety/Stress	YES	NO
Fibromyalgia	YES	NO	Seizures	YES	NO	Depression	YES	NO
Rheumatoid Arthritis	YES	NO	Peripheral Neuropathy	YES	NO	Bipolar	YES	NO
ENDOCRINE			Parkinsons Disease	YES	NO	ADD/ADHD	YES	NO
Diabetes Type 1	YES	NO	Stroke	YES	NO	OTHER	YES	NO
Diabetes Type 2	YES	NO	Amputee: ________			AIDS/HIV	YES	NO
Thyroid: ________	YES	NO	Implantable Device: ________			MRSA	YES	NO

Review of Systems

Constitutional
- ☐ none
- ☐ recent weight change
- ☐ chills
- ☐ fever
- ☐ weakness/fatigue
- ☐ other ________

Eyes
- ☐ none
- ☐ vision change
- ☐ glasses/contacts
- ☐ cataracts
- ☐ glaucoma
- ☐ other ________

Ear, Nose, Throat
- ☐ none
- ☐ hearing loss
- ☐ ear ache
- ☐ ringing in ear
- ☐ other ________

Cardiovascular
- ☐ none
- ☐ chest pain
- ☐ swelling in legs
- ☐ palpitations
- ☐ other ________

Repiratory
- ☐ none
- ☐ shortness of breath
- ☐ wheezing, asthma
- ☐ frequent cough
- ☐ other ________

Musculoskeletal
- ☐ none
- ☐ muscle aches
- ☐ swelling of the joints
- ☐ stiffness in joints
- ☐ other ________

Skin
- ☐ none
- ☐ rash
- ☐ ulcers
- ☐ abnormal scars
- ☐ other ________

Neurological
- ☐ none
- ☐ headaches
- ☐ dizziness
- ☐ numbness/tingling
- ☐ loss of sensation
- ☐ other ________

Psychiatric
- ☐ none
- ☐ depression
- ☐ nervousness
- ☐ anxiety
- ☐ mood swings
- ☐ other ________

Endocrine
- ☐ none
- ☐ excessive thirst or hunger
- ☐ hot / cold intolerance
- ☐ hot flashes
- ☐ other ________

Hematologic
- ☐ none
- ☐ easy bruising
- ☐ easy bleeding
- ☐ anemia
- ☐ other ________

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PREVIOUS SURGERIES			SOCIAL HISTORY
Y	N		
☐	☐	prior problems with anesthesia	
☐	☐	gallbladder	
☐	☐	appendix	
☐	☐	prostate	
☐	☐	hysterectomy/ovaries	
☐	☐	heart stents	
☐	☐	heart bypass	
☐	☐	heart valve surgery	
☐	☐	spine surgery	
☐	☐	hip surgery	
☐	☐	knee surgery	
☐	☐	shoulder surgery	
☐	☐	hand surgery	
☐	☐	gastric band/bypass	
☐	☐	other surgeries (list):	

SOCIAL HISTORY: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed
Number of Children: ______
Presently living alone? ☐ Yes ☐ No
With which hand do you write: ☐ right ☐ left ☐ both

Do you currently use a cane or walker? ☐ Yes ☐ No
Do you smoke? ☐ Never ☐ Yes ☐ No
If no, when did you quit: ______
If yes, how many packs per day: ______
If yes, how many years: ______

Alcohol:
☐ Never ☐ Never, but I used to ☐ Occasional ☐ Moderate-to-heavy use
# of drinks per day ______ ☐ Prior Alcohol Abuse Problem

Drug Problem:
☐ Never ☐ Present ☐ Past Problem

Optional: Spiritual History
Your church affliation: ______ You put your faith in: ______
☐ I rely on prayer ☐ I would like to understand how my faith affects my health
☐ I would like to know more about the christian faith

Are you allergic to any medications? ☐ **Yes** ☐ **No**
If yes, list medication(s) & the reaction:

Medication	**Allergic Reaction**

Food Allergy: ______ LATEX Allergy ☐ Yes ☐ No
Metal, Nickel, Jewelry Allergy: ______ Other Allergy: ______

Current Medications:

Drug Name	**Form (tablet, liquid, etc.)**	**Dose**	**Frequency**

Preferred Pharmacy: ______ City: ______ Phone: ______

FAMILY HISTORY

	Yes	No	If Yes, check all to whom it applies					
			Family	Father	Mother	Sibling	Child	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Anesthesia	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐

Clinical Staff: By signing here, I certify that I have reviewed this information with the patient/guardian and it is correct as stated. Any corrections or additions to the patient's original entries have been initialed by the patient. I have reviewed this information with patient as part of today's exam and submitted into the EHR.

Signature Date