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
Birthdate
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	HEALTH Good	Fair	Poor	IF DECEASED Death Age	Death Cause
Father						
Mother						
Brothers Sisters (Circle Sex)						
1. M F						
2. M F						
3. M F						
4. M F						
5. M F						
Husband ☐ Wife ☐						
Sons Daughters (Circle 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				Hey 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 ☐
- Antibiotics ☐
- Aspirin, Bufferin, Anacin ☐
- Barbiturates ☐
- Birth Control Pills ☐
- Blood Pressure Pills ☐
- Blood Thinning Pills ☐
- Cortisone ☐
- Cough Medicine ☐
- Digitalis ☐
- Dilantin ☐
- Hormones ☐
- Insulin, Diabetic Pills ☐
- Iron or Poor Blood Med. ☐
- Laxatives ☐
- Phenobarbital ☐
- Shots ☐
- Sleeping Pills ☐
- Thyroid Med. ☐
- Tranquilizers ☐
- Vitamins ☐
- Water Pills ☐
- Weight Reducing Pills ☐
- Other (list) ______

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 miscarrige? ☐ ☐ 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 complication 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 from sleep? ☐ ☐
- 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

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

Do you frequently have: ✓Yes No

- Bleeding gums? ☐ ☐
- Trouble swallowing? ☐ ☐
- Hoarseness? ☐ ☐
- A sore tongue? ☐ ☐
- Nausea and vomiting? ☐ ☐

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? ☐ ☐
- 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: — **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 the 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.

______