HISTORY　　　　MRN

NAME:　MARITAL STATUS: ❑ S ❑ M ❑ W ❑ D ❑ SEP.　DATE OF BIRTH:　DATE:

OCCUPATION/EMPLOYER　PHONE (H):　PHONE (W):

SS#:　INSURANCE #:

FAMILY HISTORY　IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) ALCOHOLISM	6) CANCER	11) HEART DISEASE	16) OSTEOPOROSIS
2) ANEMIA	7) DIABETES	12) HYPERTENSION	17) STROKE
3) ASTHMA	8) EPILEPSY	13) KIDNEY DISEASE	18) THYROID
4) ARTHRITIS	9) GLAUCOMA	14) MENTAL ILLNESS	19)
5) BLEEDS EASILY	10) HAYFEVER	15) MIGRAINE	20)

HOSPITAL ADMISSIONS　YEAR　ILLNESS OR OPERATION

(not including pregnancies)

ALLERGIES

Past:

Present:

LIST ALL MEDICATIONS YOU ARE NOW TAKING: (including Over the Counter)

1) ____________　7) ____________
2) ____________　8) ____________
3) ____________　9) ____________
4) ____________　10) ____________
5) ____________　11) ____________
6) ____________　12) ____________

VACCINE (Date of Last)

Tetanus / Diphtheria
Influenza
Pneumococcal
Hepatitis

TEST / EXAM (Date of Last)

Cholesterol
Dental
Eye
Hearing
Rectal / Stool
Sigmoidoscopy
Tuberculosis Skin Test

MEDICAL HISTORY

Check (✓) and indicate age when you had any of the following symptoms or diseases. MARK (X) for current problems.

MAIN PROBLEMS 1) ____________ 2) ____________ 3)____________

❑ Decreased Hearing
❑ Ringing in Ear
❑ Ear Infections - *frequent*
❑ Dizzy Spells
❑ Failing Vision ❑ Eye Pain
❑ Double or Blurred Vision
❑ Eye Infections - *frequent*
❑ Nose Bleeds - *recurrent*
❑ Sinus Trouble
❑ Sore Throats - *frequent*
❑ Hayfever / Allergies
❑ Hoarseness - *prolonged*
❑ Pneumonia / Pleurisy
❑ Bronchitis / Chronic Cough
❑ Asthma / Wheezing
Shortness of Breath:
❑ on Exertion ❑ Lying Flat
❑ Chest Pain
❑ High Blood Pressure
❑ Heart Murmur
❑ Irregular Pulse ❑ Palpitations
❑ Swollen Ankles
❑ Fainting Spells
❑ Leg Pain - *Walking*
❑ Varicose Veins / Phlebitis

❑ Loss of Appetite - *recent*
❑ Difficulty Swallowing
❑ Indigestion or Heartburn
❑ Peptic Ulcers
❑ Abdominal Pain - *Chronic*
❑ Gall Bladder Trouble
❑ Jaundice / Hepatitis
❑ Change in Bowel Habits
❑ Diarrhea ❑ Constipation
❑ Diverticulosis
❑ Crohn's / Colitis
❑ Bloody or Tarry Stools
❑ Hemorrhoids
❑ Hernia
❑ Urine Infections - frequent
❑ Blood in Urine
Urination ❑ Overnight >than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force / Flow
❑ Kidney Stones
❑ Venereal Disease
❑ Urethal Discharge
❑ Chronic Fatigue
❑ Weight Loss - *recent*
❑ Anemia ❑ Bruise Easily

❑ Cancer
❑ Diabetes
❑ Thyroid Disease
❑ Convulsions / Seizures
❑ Stroke
❑ Tremor / Hands Shaking
❑ Muscle Weakness
❑ Numbness /Tingling Sensations
❑ Headaches - *frequent*
❑ Arthritis / Rheumatism
❑ Back Pain - *recurrent*
❑ Bone Fracture / Joint Injury
❑ Gout
❑ Osteoporosis
❑ Foot Pain
❑ Cold Numb Feet
❑ Rashes
❑ Hives
❑ Psoriasis
❑ Eczema
❑ Sleeping - *difficulty*
❑ Nervousness
❑ Depression
❑ Memory Loss
❑ Moodiness - *excessive*

❑ Phobias
❑ Mental Illness
❑ Chicken Pox
❑ Polio
❑ Mumps
❑ Measles
❑ German Measles
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Tuberculosis
❑ Herpes
❑ Contact with Blood or Body Fluids
❑ Alcohol ____oz. per week
❑ Smoking ____ cig. per day
Number of years _______
❑ Coffee / Tea
# of cups per day ______
❑ Advanced Directives

MALES - Please Complete
Date of last prostate exam
❑ Normal ❑ Abnormal

Date of Last PSA ____________

FEMALES - Please Complete
Menstrual Flow:
❑ Reg. ❑ Irreg.
❑ Pain / Cramps
Days of Flow _________
Lengths of Cycle ______
Date ________of last period______
❑ Pain / Bleeding during or after sex
Number of :
Pregnancies ______
Abortions ______
Miscarriages _______
Live Births _______
Birth Control Method __________
B. C. Pill (Name) ______________
❑ Flushing / Menopause
Date of last pelvic exam ________
Date of last PAP test ____________
❑ Normal ❑ Abnormal

Date of last breast exam ________

Date of last Mammogram
❑ Normal ❑ Abnormal

SYNOPSIS　**OFFICE USE ONLY:**　**Advance Directive: ❑ Yes ❑ No**　**Advance Directive Education ❑**

STAYING HEALTHY ASSESSMENT Date:__________________

Signature:　M.D.