HISTORY

MRN #

NAME:

MARITAL STATUS:
❑ S ❑ M ❑ W ❑ D ❑ SEP.

DATE OF BIRTH:
PHONE (H):
SS#:

DATE:
PHONE (W):
INSURANCE #:

OCCUPATION/EMPLOYER

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 (not including pregnancies)

YEAR

ILLNESS OR OPERATION

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.