

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

We ask that you take the time to fill out this medical history. The doctor will review this with you at the time of your visit. The more detail you can provide us about your past history, the more accurate your record will be and the more time we will have to discuss your medical problems, explain them to you, review all of the treatment options and answer your questions.

Please list the names and addresses of any **DOCTORS** who should receive reports.

Name	Address	Phone	Fax
Example: Dr. Joe Jones	3315 W. Arcadia, Stockton, CA 94355	555-324-5555	555-324-5556

### Cardiovascular History

Problem or Symptom	Yes or No	Details
Heart Attack	Yes No	
Stroke	Yes No	
High Blood Pressure	Yes No	
Thyroid disease	Yes No	
Heart murmur	Yes No	
Enlarged heart	Yes No	
Rheumatic fever	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Palpitations	Yes No	
Chest pain or pressure	Yes No	
Near fainting	Yes No	
Fainting	Yes No	
Shortness of breath with exercise	Yes No	
Prop your head up with pillows at night	Yes No	
Wake up short of breath	Yes No	
Swelling of ankles	Yes No	
Other	Yes No	



## Family History

Relationship	Alive or Deceased	Age now or at death	Medical Problems	Cause of death
Example: Father	A D	55	Diabetes, high blood pressure	Heart attack
Maternal GM				
Maternal GF				
Paternal GM				
Paternal GF				
Mother				
Father				
Brothers				
Sisters				
Sons				
Daughters				
Other				

### Smoking History

Did you ever smoke regularly? (circle)                      yes      no

Do you still smoke? (circle)                                      yes      no

If you ever smoked regularly or still smoke, how many pack-years did you smoke (multiply average # of packs per day by # of years smoked)? \_\_\_\_\_

If you quit, what year did you quit? \_\_\_\_\_

### Alcohol History

How much and what do you drink at the present time? \_\_\_\_\_

What is your past drinking history? \_\_\_\_\_

### Caffeine History

How much caffeine do you use at the present time? \_\_\_\_\_

What is your past caffeine history? \_\_\_\_\_

## Social History

Are you ...?(circle) Single Married Divorced Widowed Remarried Other

Do you practice any specific religion? \_\_\_\_\_

Birthplace \_\_\_\_\_

Current Occupation \_\_\_\_\_

## General Medical Review

Symptom/disease	Present	Details
<b>Constitutional</b>		
Recent weight change	Yes No	
fatigue	Yes No	
Recurrent fevers, sweats	Yes No	
Other	Yes No	
<b>Eyes</b>		
Wear glasses/contact	Yes No	
Glaucoma	Yes No	
Cataracts	Yes No	
Blurred or double vision	Yes No	
other	Yes No	
<b>Ears/Nose/Throat</b>		
Decreased hearing	Yes No	
Hearing aides	Yes No	
Ringing in ears	Yes No	
Chronic sinusitis	Yes No	
Hay fever	Yes No	
Bleeding gums	Yes No	
Voice changes	Yes No	
other	Yes No	
<b>Respiratory</b>		
asthma	Yes No	
Emphysema	Yes No	
Coughing up blood	Yes No	
Chronic cough	Yes No	
History of TB	Yes No	
Other	Yes No	
<b>Gastrointestinal</b>		
Change in appetite	Yes No	
Severe heartburn	Yes No	
Stomach ulcers	Yes No	
Frequent nausea/vomiting	Yes No	
Vomiting blood	Yes No	
Frequent diarrhea	Yes No	
Chronic constipation	Yes No	
Rectal bleeding	Yes No	
Black or bloody stools	Yes No	
Chronic abdominal pain	Yes No	
Diverticulitis	Yes No	
Hepatitis/liver disease	Yes No	

<b>Genitourinary</b>		
Blood in urine	Yes No	
Burning with urination	Yes No	
Frequent urinary infections	Yes No	
Difficulty controlling urine	Yes No	
Change in sexual function	Yes No	
Prostrate trouble (men)	Yes No	
Pain/problems with period (women)	Yes No	
Post menopausal (women)	Yes No	
Other	Yes No	
<b>Neurological</b>		
Chronic headaches	Yes No	
Convulsions/seizures	Yes No	
Change in memory	Yes No	
Weakness or paralysis	Yes No	
other	Yes No	
<b>Psychiatric</b>		
Depression	Yes No	
Change in sleep	Yes No	
Other	Yes No	
<b>Musculoskeletal</b>		
Arthritis	Yes No	
Chronic back problems	Yes No	
Other	Yes No	
<b>Hematologic</b>		
Easy bruising	Yes No	
Prior or present anemia	Yes No	
other	Yes No	

### General Questions

How did you hear about our practice? \_\_\_\_\_

Did you have any problems with or complaints about arranging your appointment?

\_\_\_\_\_

After your visit, we welcome your feedback as to how we could have served you better.

If you had to wait too long to get an appointment or wait too long at the time of your visit, we want to know about it but we assure you we do the best we can in a busy, difficult healthcare system.

ROS reviewed by MD: \_\_\_\_\_

