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**	

Cholesterol History

Date	Total Cholesterol	HDL (good)	LDL (bad)	Triglycerides

Previous Surgery

Type of surgery	Year	Comments
Example: Tonsils and Adnoids	1955	I was a child and don't remember much.

Medications (included vitamins and supplements) and Dosages

Name of Medicine	Dosage of Pill	How much do you take?	How often is it taken.
Example: Lasix	20 mg	2 tablets	3 times a day

Allergies

List all drug, tape, seasonal, food, or other allergies	List what happens to you
Example: Penicillin	rash

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
Constitutional		
Recent weight change	Yes No	
fatigue	Yes No	
Recurrent fevers, sweats	Yes No	
Other	Yes No	
Eyes		
Wear glasses/contact	Yes No	
Glaucoma	Yes No	
Cataracts	Yes No	
Blurred or double vision	Yes No	
other	Yes No	
Ears/Nose/Throat		
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	
Respiratory	Yes No	
asthma	Yes No	
Emphysema	Yes No	
Coughing up blood	Yes No	
Chronic cough	Yes No	
History of TB	Yes No	
Other	Yes No	
Gastrointestinal		
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	

Genitourinary		
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	
Neurological		
Chronic headaches	Yes No	
Convulsions/seizures	Yes No	
Change in memory	Yes No	
Weakness or paralysis	Yes No	
other	Yes No	
Psychiatric		
Depression	Yes No	
Change in sleep	Yes No	
Other	Yes No	
Musculoskeletal		
Arthritis	Yes No	
Chronic back problems	Yes No	
Other	Yes No	
Hematologic		
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: _____