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	Birth date	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			IF DECEASED	
	Age	HEALTH Good Fair Poor		Death Age	Death Cause
Father					
Mother					
Brothers (Circle Sisters Sex)					
1. M F					
2. M F					
3. M F					
4. M F					
5. M F					
Husband ☐ Wife ☐					
Sons (circle Daughters 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

Condition	✔ Yes	No	Relationship	Condition	✔ Yes	No	Relationship
Asthma				Hay 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 ☐	Blood Thinning Pills ☐	Iron or Poor Blood Med. ☐	Vitamins ☐
Antibiotics ☐	Cortisone ☐	Laxatives ☐	Water Pills ☐
Aspirin, Bufferin, Anacin ☐	Cough Medicine ☐	Phenobarbital ☐	Weight Reducing Pills ☐
Barbiturates ☐	Digitalis ☐	Shots ☐	Other (list) ______
Birth Control Pills ☐	Dilantin ☐	Sleeping Pills ☐	______
Blood Pressure Pills ☐	Hormones ☐	Thyroid Med. ☐	______
	Insulin, Diabetic Pills ☐	Tranquilizers ☐	

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 miscarriage? ☐ ☐ 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 complications 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?	☐	☐
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 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:

	✔ Yes	No	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 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.