

## Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

### General:

Name:	Birthdate:	Family Dr:
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Date of your last complete physical exam?	Date of your last chest X-ray?
Date of your last cholesterol screening?	Date of your last dental exam?
Date of your last eye exam?	Date of your last sigmoidoscopy?

<b>Women:</b>	<b>Men:</b>
Date of last mamogram?	Date of last PSA?
Date of last pap smear?	Date of last rectal/prostate exam?

<b>Immunizations:</b>		Pneumonia	Date:
Measles - Mumps - Rubella (MMR)	Date:	Hepatitis B	Date:
Tetanus and diphtheria toxoids (Td)	Date:	Influenza	Date:

<b>Past Medical History: (check those that apply)</b>			
<input type="checkbox"/> AIDS or HIV +	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood or Plasma Transfusions	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Infectious Mononucleosis	<input type="checkbox"/> Polio	<input type="checkbox"/> Whooping Cough

<b>Hospital / Surgical History:</b>			
Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

<b>Allergies:</b>
Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction.

<b>Medications:</b>		
Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.		
1)	4)	7)
2)	5)	8)
3)	6)	9)

<b>Social History:</b>												
Occupation:					Marital Status:							
Do you exercise regularly?		YES	NO	What type?			How often?					
I have never smoked.		YES	NO	I currently smoke _____ packs per day.			I have smoked for _____ years.					
I formerly smoked but stopped in: _____ (list year)					Do you wear seat belts?			YES	NO			
Do you use other forms of tobacco?		YES	NO	Do you use illicit drugs?		YES	NO	Do you drink alcohol?		YES	NO	
How often/how much?			How often/how much?			How often/how much?						
Do you have any risk factors for HIV infection?				YES	NO	Have you ever been exposed to anyone with tuberculosis?				YES	NO	
Have you had excessive exposure to sun because of your work or recreation?										YES	NO	
Are you currently experiencing unusual stress?				YES	NO	Explain:						
Are there any environmental risks involved in your job or home environment?										YES	NO	Explain:

<b>Family History:</b>											
Relationship			Relationship			Relationship			Relationship		
<input type="checkbox"/>	Anemia		<input type="checkbox"/>	Epilepsy		<input type="checkbox"/>	High cholesterol		<input type="checkbox"/>		
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	Glaucoma		<input type="checkbox"/>	Kidney disease		<input type="checkbox"/>		
<input type="checkbox"/>	Obesity		<input type="checkbox"/>	Leukemia		<input type="checkbox"/>	Thyroid disease		<input type="checkbox"/>		
<input type="checkbox"/>	Cancer		<input type="checkbox"/>	Depression		<input type="checkbox"/>	High blood pressure		<input type="checkbox"/>		
<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	Heart disease		<input type="checkbox"/>	Alcohol problems		<input type="checkbox"/>		
<input type="checkbox"/>	Stroke		<input type="checkbox"/>	Lung disease		<input type="checkbox"/>	Bleeding Tendency		<input type="checkbox"/>		

<b>Present Age or Age of Death:</b>			Mother:			Father:				
Sibling #1			Sibling #2			Sibling #3				
<b>Women Only:</b> Menstrual Period Onset:			Regular?		YES	NO	Date last period began:			
Age at menopause:		Difficulty with periods?		YES	NO	Specify:				
Pregnancies: No. of children:		Born Alive:		Cesarean:		Premature:		Stillborn:		Miscarriages:
Describe complications:										

**Please check all conditions you currently have or have had:**

<p><b>General Questions</b>                  Weight loss                  Weight gain                  Change in sleep patterns                  Change in activity capacity</p> <p><b>Neurologic and Psychiatric</b>                  Anxiety                  Headaches                  Depression                  Meningitis                  Paralysis                  Seizure                  Stroke                  Tingling                  Tremors                  Memory Loss                  Fainting spells, dizziness                  Head injuries                  Blackouts or near blackouts                  Change in sensation                  anywhere on your body                  Localized weakness or                  numbness</p> <p><b>Ears, Eyes, Nose &amp; Throat</b>                  Hay fever                  Glaucoma                  Polyps                  Allergy                  Cataracts                  Goiter                  Hoarseness                  Double vision                  Gum problems                  Eye problems                  Ear Infections                  Glasses/contacts                  Hearing Loss                  Ear discharge/pain                  Frequent nosebleeds                  Ringing in your ears                  Sinus infecti                  Swollen glands</p>	<p><b>Cardiovascular</b>                  Angina           Chest pain                  Leg cramps       Murmurs                  Ankle swelling                  Awakening at night short of                  breath &amp; getting out of bed                  Cardiac catheterization                  Cold hands or feet                  Congenital heart defects                  Dizziness when standing                  up quickly                  Heart attacks                  Heart failure                  High or low blood pressure                  Irregular heart rate                  Purple fingers or lips                  Leg pain that resolves                  with rest                  Heart palpitations                  Varicose veins</p> <p><b>Respiratory</b>                  Pleurisy           Wheezing                  Asthma                  Breathlessness when lying flat                  Prolonged cough                  Coughing up blood                  Emphysema                  Shortness of breath                  Tuberculosis                  Pneumonia                  Frequent infections (bronchitis)</p> <p><b>Skin</b>                  Abscess           Dandruff                  Acne               Oily skin                  Boils               Rashes                  Hives               Dry skin                  Lumps              Psoriasis                  Jaundice                  Athlete's foot                  Excessive body odor                  Excessive sweating                  Fungal infections                  Nail problems                  Moles- irregular                  Moles - change/new</p>	<p><b>Kidneys &amp; Urinary Tract</b>                  Blood in urine                  Brown urine                  Dribbling after urination                  Painful urination                  Excessive thirst                  Involuntary urination/incontinence                  Urinating frequently (day)                  Urinating frequently (night)                  Urine hesitancy                  Weak flow                  Frequent bladder infections                  Kidney disease                  Kidney stone</p> <p><b>Endocrine</b>                  Diabetes           Sickle cell                  Abnormal body hair                  Changes in skin texture                  Cold intolerance                  Heat intolerance                  History of "borderline" diabetes                  Increased loss of hair                  Rheumatism                  Thyroid disease</p> <p><b>Male &amp; Female</b>                  Painful sexual intercourse                  Loss of sexual interest                  Unprotected sex                  Groin itching                  Sexually transmitted diseases</p> <p><b>Males Only</b>                  Hernia              Sterility                  Bloody ejaculation                  Inability to complete                  intercourse                  Lump on testicle                  Penile discharge                  Premature ejaculation                  Problems maintaining or                  keeping an erection                  Prostate disease                  Sores on penis or warts                  Testicular pain                  Testicular swelling</p>	<p><b>Musculoskeletal</b>                  Anemia            Arthritis                  Back pain         Bursitis                  Gout               Joint aches                  Neck pain         Tendinitis                  Abnormal Blood Counts                  Blood clots in legs/lungs                  Bone Marrow Biopsy                  Easy Bleeding                  Easy bruising                  Joint swelling                  Morning stiffness                  Muscle aches</p> <p><b>Gastrointestinal</b>                  Diarrhea          Gallstones                  Reflux             Vomiting                  Ulcers             Heartburn                  Hepatitis          Indigestion                  Abdominal pain                  Anal fissures                  Black tarry stools                  Vomiting blood                  Constipation                  Nausea                  Problems swallowing                  Hiatal Hernia                  Intestinal obstruction                  Liver disease                  Hemorrhoids                  Red blood after bowel                  movements</p> <p><b>Females Only</b>                  D + C              Hot flashes                  Hernia             Fibroids                  Abn. bleeding between cycles                  Abnormal pap smear                  Bleeding after intercourse                  Complications w/ pregnancy                  PMS                  Endometriosis                  Heavy bleeding during cycles                  Discharge from breast                  Ovarian cysts                  Pelvic Inflammatory Disease                  Postmenopausal symptoms                  Vaginal discharge                  Vaginal Dryness                  Vaginal warts</p>
<p>Provider Notes</p>			
<p> </p>			
<p> </p>			
<p><b>Provider Signature</b></p>		<p><b>Date</b></p>	