

**PATIENT MEDICAL HISTORY**

**NAME** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_

**OTHER DOCTORS YOU SEE:** \_\_\_\_\_

**Describe what medical problems you are having:**

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**List Medications and dosages**

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**List any Allergies to medications and type of reaction**

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**Other medical problems you may have**

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**List dates and reason for any hospitalizations, Surgeries or injuries**

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

**FAMILY MEDICAL HISTORY**

Has anyone of the following family members died as a result of or currently have a hereditary disease such as: Colorectal Cancer, Heart Disease, Diabetes, etc. IF yes, please list disease below

Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Sibling \_\_\_\_\_  
Children \_\_\_\_\_

Has anyone in your family had Colon Cancer? Yes No Who? \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? YES NO How much? \_\_\_\_\_  
Do you drink alcohol? YES NO How much? \_\_\_\_\_

**REVIEW OF SYMPTOMS**

**General**

- Anemia
- Bruise easily/bleed to long
- Diabetes
- Chronic Fatigue
- Cancer
- Weight Loss
- Transfusion
- Thyroid Disease
- Fever
- What kind? \_\_\_\_\_
- Amount \_\_\_\_\_
- Since when \_\_\_\_\_

**Gastrointestinal**

- Diarrhea
- Heartburn
- Abd. Pain
- Blood in Stool
- Liver Disease
- Trouble swallowing
- Polyps
- Diverticulitis
- Constipation
- Nausea
- Vomiting
- Bloating
- Gas
- Colon Cancer

**Ears, Nose, Throat**

- Ringing in ears
- Glaucoma
- Dizzy Spells
- Sinus
- Poor vision
- Hoarseness

**Urinary/Reproductive**

- Urine Infections
- Blood in urine
- Decreased flow or force
- Urination at night (more than 2 times)
- Endometriosis
- Date of last Menstrual Cycle \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- # of live births \_\_\_\_\_
- Kidney Stones
- Painful urination

**Lungs**

- Emphysema/COPD
- Asthma
- Short of Breath
- Chronic Bronchitis
- Chronic Cough
- Coughing up Blood

**Heart**

- Chest Pain
- High Blood Pressure
- Irregular Heart Beat
- Phlebitis
- Palpitations
- Ankle Swelling
- Heart Murmur
- Heart Valve Problem

**Bones & Joints**

- Arthritis
- Osteoporosis

**Neurologic/Psychiatric**

- Numbness or Tinglir
- Frequent Headache:
- Tremor
- Depression
- Nervousness/Anxiet
- Stroke
- Migraines
- Seizure
- Memory Loss
- Panic Attacks

**Skin (skin, allergic, immunologic)**

- Rash
- Allergic reactions
- Type(s) \_\_\_\_\_
- \_\_\_\_\_

**Other Problems**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_