Chart No.
Social Security No. ____/____/____

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **PLEASE PRINT AND COMPLETE ALL INFORMATION**

M.D. SIGNATURE

Today's Date
Birthdate
Male ☐ Female ☐

Last Name	First	Middle	Marital Status S M D W	Occupation

PAST ILLNESSES - Have you had?

Yes	No		Yes	No		Yes	No	
___	___	Measles	___	___	Diabetes	___	___	Mononucleosis
___	___	Mumps	___	___	Kidney Disease	___	___	Blood Transfusion
___	___	Chicken Pox	___	___	Boils	___	___	Sexually Transmitted Disease
___	___	Scarlet Fever	___	___	Tonsillitis	Please list any others below:		
___	___	3-Day Measles	___	___	Anemia	___	___	_____
___	___	Arthritis	___	___	Whopping Cough	___	___	_____
___	___	Pneumonia	___	___	Epilepsy	___	___	_____
___	___	Yellow Jaundice	___	___	Polio	___	___	_____

Yes ___ No ___ Are your childhood and/or adult immunizations up-to-date?

ALLERGIES

List all drugs you are allergic to:

_____

_____

_____

_____

_____

Yes	No	Do you have?
___	___	Asthma
___	___	Hay Fever
___	___	Foods
___	___	Rashes or Eczema
___	___	Penicillin
___	___	Sulfa

HABITS

Yes	No		Daily Consumption:
___	___	Smoke	_____ pkgs.
___	___	Coffee	_____ cups
___	___	Alcohol	_____ oz.
___	___	Beer	_____ cans
___	___	Fall asleep easily	
___	___	Awaken early	

ALL CURRENT MEDICATIONS Prescription and over the counter meds. _____ _____ _____ _____ _____ _____

SOCIAL HISTORY

Do you live in a house ___, apartment ___, other ___

___ How many people live with you?

___ How long have you lived at your present address?

___ Have you been in the military?

OPERATIONS

Year	Brief Description
_____	_____
_____	_____
_____	_____

FAMILY HEALTH HISTORY

	- If Living - Age	Good / Fair / Poor:	- If Deceased - Age	Cause of Death
Father	___	___/___/___	___	_____
Mother	___	___/___/___	___	_____
Brother/Sister	___	___/___/___	___	_____
(Circle Sex)	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
__ Husband	___	___/___/___	___	_____
__ Wife	___	___/___/___	___	_____
Son/Daughter	___	___/___/___	___	_____
(Circle Sex)	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
M F	___	___/___/___	___	_____
M F	___	___/___/___	___	_____

Any blood relatives who have or have had any of the following:

(If yes)	Relationship		Relationship
___ Asthma	_____	___ Heart Disease	_____
___ Alcoholism	_____	___ Hay Fever	_____
___ Allergies	_____	___ Insanity	_____
___ Anemia	_____	___ Kidney Disease	_____
___ Bleeding Ten.	_____	___ Leukemia	_____
___ Colitis	_____	___ Migraine	_____
___ Depression	_____	___ Nervous Breakdown	_____
___ Diabetes	_____	___ Obesity	_____
___ Epilepsy	_____	___ Rheumatism	_____
___ Goiter	_____	___ Rheumatic Fever	_____
___ High Blood P.	_____	___ Stroke	_____
___ Cancer	_____	___ Suicide	_____
___ (list type)	_____	___ Stomach Ulcers	_____
___ _____	_____	___ Tuberculosis	_____
___ _____	_____	___ _____	_____
___ _____	_____	___ _____	_____

100 Important Health Questions

	Yes	No
1. Has your general health been poor?		
2. Have you had trouble with your eyes, ears, nose and throat?		
3. Is your vision blurred or do you have abnormal vision or other eye problems?		
4. Do you see halos around lights at night?		
5. Do you have ear discharge		
6. Have you noticed hearing loss?		
7. Do you have ringing in your ears?		
8. Do you have trouble with your teeth?		
9. Do you have sore throats or hoarseness?		
10. Have you had neck problems?		
11. Have you had a goiter or thyroid disease?		
12. Do you have trouble swallowing?		
13. Do you cough frequently?		
14. Are you troubled with persistent or frequent shortness of breath?		
15. Have you ever coughed up blood?		
16. Do you wheeze when you breathe?		
17. Do you have frequent chest colds?		
18. Do you have discomfort walking up stairs?		
19. Do you have chest pains?		
20. Have you ever had a heart murmur or heart trouble?		
21. Have you had a heart attack?		
22. Do you have varicose veins?		
23. Have you ever had trouble with your breasts or nipples?		
24. Have you had breast tumors?		
25. Is there a history of breast disease in your family?		
26. Are there foods which you cannot eat?		
27. Do you vomit frequently?		
28. Do you often belch or have heart burn?		
29. Are you full of gas?		
30. Do you have abdominal discomfort before or after meals		
31. Have you ever had an ulcer or ulcer symptoms?		
32. Have you had black tarry stools or clay colored stools?		
33. Do you have frequent loose stools?		
34. Are you constipated?		

	Yes	No
35. Do you experience urgency to have bowel movements frequently?		
36. Do you bleed from the rectum?		
37. Have you had hepatitis or gall bladder disease?		
38. Do you have persistent abdominal pain?		
39. Do you have or have you had a hernia?		
40. Do you have to get up at night to pass urine? If so how many times?		
41. Do you have urinary urgency at times?		
42. Do you ever feel as if your bladder does not empty completely?		
43. Is your urinary stream usually weak or slow?		
44. If you laugh, cough or sneeze, do you wet yourself?		
45. Have you had kidney or bladder infections?		
46. Does your urine burn you?		
47. Does your urine have an unusual color or odor?		
48. Have you noticed a diminished sexual desire?		
49. Do you have back pain or stiffness?		
50. Have you had back trouble in the past?		
51. Does your back limit your work in any way?		
52. Are you troubled with weakness or numbness in your arms or legs?		
53. Do you often have cold hands or feet?		
54. Do your hands and/or feet swell?		
55. Are your extremities often discolored?		
56. Do you have painful joints?		
57. Are you usually unhappy?		
58. Are you a nervous person?		
59. Do you become depressed easily?		
60. Have you ever contemplated suicide?		
61. Do you sleep poorly at night?		
62. Do you wake up after going to sleep and then find yourself unable to get back to sleep?		
63. Have you fainted?		
64. Have you ever been unconscious?		
65. Do you have lumps or tumors on your body?		
66. Do you always wear seat belts in a car?		

FOR MEN

	Yes	No
67. Are you troubled by being unable to start the urinary stream?		
68. Does your urinary stream stop while you are urinating only to have it start again in a few seconds?		
69. Do you dribble urine after having stopped?		
70. Have you had discharge from the penis?		
71. Have you had lumps on your testicles?		
72. Do you have any trouble with impotence?		
73. Are you unable to reach sexual climax?		
74. Do you feel that you have sexual problems?		
75. Do you do monthly testicular self-examination?		

FOR WOMEN

Date of last mammogram _____/_____/_____

	Yes	No
76. Have you had any pelvic (female) operations?		
77. Have you ever had a pelvic infection?		
78. Do you have hot flashes?		
79. Are you on birth control pills or estrogen?		
80. Do you have an IUD?		
81. Do you have pain/bleeding with intercourse?		
82. Do you spot between periods?		
83. Do you have pain with periods?		
84. Are you unable to reach sexual climax?		

85. How old were you when you had your first period? _____
86. How frequent are your periods? (first day of cycle to first day of next cycle) _____
87. Are your periods (circle) light, heavy, or medium? How long do they last (days)? _____
88. When was your last menstrual period (first day)? _____
89. How long do you flow heavily? _____
90. How man pads do you use per period? _____
91. How man full term pregnancies (9 months) have you had? _____
92. How many miscarriages? _____
93. How many premature babies? _____
94. How man living children? _____
95. Have you had an abortion(s) _____ (Number) _____
96. How long was your last labor? _____
97. How large was your biggest baby (pounds)? _____
98. How small was your smallest baby? _____

	Yes	No
99. Do you feel that you have sexual problems?		
100. Do you do monthly self breast exam?		

Reviewed: _____ _____/_____/_____
M.D. Date

ADDITIONAL HISTORY

LIST OTHER THINGS ABOUT YOUR HEALTH YOU WISH THE DOCTOR TO KNOW.