Name: _____ PATIENT MEDICAL HISTORY Date:_____

Reason for Visit:_____

DOB:_____ Age:_____ Height: _____ Weight:_____

Please Mark all that apply and if Applicable date of occurrence

ENDOCRINE	**Current**	**Past**
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Pre-Diabetic/Insulin Resistant	☐	☐
Hypothyroidism	☐	☐
Hyperthyroidism	☐	☐
High Cholesterol	☐	☐
Recent Weight Gain	_____LBS	
Recent Weight Loss	_____LBS	
Fever – how high	_____° F	

SKIN/BREAST	**C**	**P**
Breast Cancer	☐	☐
Skin Cancer	☐	☐
Scleroderma	☐	☐
Brest Lump/mass	☐	☐
Breast Pain	☐	☐
Skin Lesions	☐	☐
Skin Rash	☐	☐
Skin Fold Irritation	☐	☐

ENMT	**C**	**P**
Hearing Loss	☐	☐
Bleeding Gums	☐	☐

HEMATOLOGIC/LYMPH	**C**	**P**
Blood Clot	☐	☐
Deep Vein Thrombosis	☐	☐
Superficial blood clot	☐	☐
Vena Cava Filter Placement	☐	☐
Hemophilia A	☐	☐
Carrier of Hemophilia A	☐	☐
Hemophilia B	☐	☐
Carrier Of Hemophilia B	☐	☐
Iron Deficiency Anemia	☐	☐
Anemia	☐	☐
HIV infection	☐	☐
AIDS	☐	☐
Leukemia	☐	☐
Non-Hodgkin's Lymphoma	☐	☐
Lymphoma	☐	☐
Easy Bruising	☐	☐
Swollen lymph Nodes	☐	☐

Location _____

EYES	**C**	**P**
Glaucoma	☐	☐
Blindness	☐	☐
Eye Pain	☐	☐
Visual Impairment	☐	☐
Diabetic Retinopathy	☐	☐

GASTROINTESTINAL	**C**	**P**
Gallstones	☐	☐
Diverticulosis	☐	☐
Diverticulitis	☐	☐
Irritable Bowel	☐	☐
Crohn's Disease	☐	☐
Ulcerative Colitis	☐	☐
Colon Cancer	☐	☐
Jaundice	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Chronic Liver Disease	☐	☐
Fatty Liver	☐	☐
Cirrhosis	☐	☐
Hiatal Hernia	☐	☐
Internal Hernia	☐	☐
Inguinal Hernia	☐	☐
Location _____		
Umbilical Hernia	☐	☐
Incisional Hernia	☐	☐
Ventral Hernia	☐	☐
Reflux/GERD	☐	☐
Heartburn	☐	☐
Difficulty Swallowing	☐	☐
Black/Tarry Stool	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
GI Infections	☐	☐
Abdominal Pain	☐	☐
Location _____		
Started _____		

_____ _____

Provider Signature Date

Name: _____ PATIENT MEDICAL HISTORY Date:_____

GENITOURINARY	CURRENT	PAST
Receiving Dialysis	☐	☐
Start Date _____		
Chronic Renal Failure	☐	☐
Acute Renal Failure	☐	☐
End Stage Renal Disease	☐	☐
Kidney Stones	☐	☐
Blood in Urine	☐	☐
Pain with Urination	☐	☐
Frequent Voiding	☐	☐
Stress Incontinence	☐	☐
Benign Prostate Hypertrophy	☐	☐
Male Infertility	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Female Infertility	☐	☐
Menorrhagia	☐	☐
Amenorrhea	☐	☐
Irregular Length of Period	☐	☐
Possible Pregnancy	☐	☐

CARDIOVASCULAR	C	P
Chest Pain	☐	☐
Start Date: _____		
Tachycardia	☐	☐
Rhythm Disorder	☐	☐
Murmurs	☐	☐
Pacemaker	☐	☐
Placed _____		
High Blood Pressure	☐	☐
Congestive Heart Failure	☐	☐
Limb Swelling	☐	☐
Location: _____		
Heart Attack	☐	☐
Date:_____		
Peripheral Artery Disease	☐	☐
Ischemic Heart Disease	☐	☐
Peripheral Vascular Disease	☐	☐

SLEEP APNEA – Please Answer	Yes	NO
Do you Have Sleep Apnea	☐	☐
Do you Use **CPAP** ☐ **Bipap** ☐ **Other** ☐		
Excessive/Loud Snoring	☐	☐
Daytime Sleepiness	☐	☐
Has someone observe you stop breathing while asleep	☐	☐

RESPIRATORY	CURRENT	PAST
Cough	☐	☐
Shortness of Breath	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Pulmonary Hypertension	☐	☐
Pickwickian Syndrome	☐	☐
Pulmonary Embolism	☐	☐
Date: _____		

MUSCULOSKELETAL	C	P
Arthritis	☐	☐
Location:_____		
Osteoarthritis	☐	☐
Location:_____		
Difficulty Walking	☐	☐
Use of: Wheelchair ☐ Walker ☐ Cane ☐		
Lupus	☐	☐
Sclerosis	☐	☐
Upper Back Pain	☐	☐
Lower Back Pain	☐	☐
Sciatica	☐	☐
Leg Pain	☐	☐
Muscle Cramps	☐	☐
Fibromyalgia	☐	☐
Gout	☐	☐

NEUROLOGICAL	C	P
Stroke Date:_____		
Aneurysm Date:_____		
Diabetic Neuropathy	☐	☐
Migraine Headaches	☐	☐
Convulsive Disorder	☐	☐
Seizure Disorder	☐	☐
Pseudotumor Cerebri	☐	☐
Confusion	☐	☐
Dizziness	☐	☐

MENTAL HEALTH	C	P
Bipolar Disorder	☐	☐
Anxiety Disorder	☐	☐
Personality Disorder	☐	☐
Depression	☐	☐

_____ _____

Provider Signature Date

Name: _____ PATIENT MEDICAL HISTORY Date:_____

Date of Last Mammogram: _____

Date of Last Colonoscopy: _____

Have you had a DEXA or Bone Density Scan

YES; Date _____ **NO**

SOCIAL HISTORY	**YES**	**NO**
Do you Drink Alcohol	☐	☐
How Frequently: _____		
Do you Drink Caffeine	☐	☐
Do you use Illegal Drugs	☐	☐
Do you Smoke	☐	☐
Have you ever smoked	☐	☐
Do you use other Tobacco	☐	☐

FAMILY HISTORY	**YES**	**Relation**
Heart Disease	☐	_____
Hypertension	☐	_____
Diabetes	☐	_____
Stroke	☐	_____
Cancer	☐	_____

Type and Family Member: _____

_____

Surgical History: place date next any surgery you have had in the past.

ARTERIAL SURGICAL HISTORY	**DATE**
AAA Repair	_____
Previous Coronary Artery ByPass	_____
ByPass Graft of Extremity	_____
Location: _____	
Stent Placement – Arm or Leg	_____
Temporal Artery Biopsy	_____

CARDIOVASCULAR SURGERIES	**DATE**
Heart Valve Replacement	_____
CABG – Heart ByPass	_____
Pacemaker Placement	_____
Cardioverter/Defibrillator	_____
Cath Stent Placement	_____
Lung Surgery	_____

WEIGHT LOSS SURGERY	**DATE**
Roux en Y Gastric By-pass	_____
Distal ByPass	_____
Adjustable Band	_____
Sleeve Gastrectomy	_____
LGCP	_____
BPD with DS/ without DS (circle one_)	_____
Revison/Converson to another procedure	_____

HEAD AND NECK SURGERY	**DATE**
Thyroid Surgery	_____
Parathyroid Surgery	_____
Carotid Thromboendarterectomy	_____
Tonsillectomy/Adenoidectomy	_____
Cataract Surgery	_____
Craniotomy	_____

FEMALE SURGERY	**DATE**
Breast Surgery	_____
Hysterectomy	_____
Oophorectomy	_____
Tubal Ligation	_____
Cesarean Section	_____

URINARY SURGERY	**DATE**
Nephrectomy	_____
Lithotripsy	_____
Prostate Surgery	_____
Continent Ureteral Diversion	_____

GASTROINTESTINAL SURGERY	**DATE**
Appendectomy	_____
Gallbladder Surgery	_____
Partial Colectomy	_____
Colostomy	_____
Ileostomy	_____
Hemorrhoidectomy	_____
Small Bowel Resection	_____
Splenectomy	_____
Pancreatectomy	_____
Ulcer Care	_____
Liver Transplant	_____

HERNIA SURGERY	**DATE**
Inguinal Hernia Repair Right Left	_____
Umbilical Hernia Repair	_____
Femoral Hernia Repair Right Left	_____
Incisional Hernia Repair	_____
Ventral Hernia Repair	_____
Internal Hernia Repair	_____
Hiatal Hernia/Nissan Fundiplication	_____

MUSCULOSKELETAL SURGERY	**DATE**
Back Surgery	_____
Total Hip Replacement Right Left	_____
Knee Replacement Right Left	_____
Rotator Cuff Repair	_____
Fracture: Location:_____	_____

_____ _____

Provider Signature Date

Name: _____ PATIENT MEDICAL HISTORY Date:_____

Have you had any fall with injuries: _____ If yes, how long ago: _____

MEDICATIONS

Please list all medications you take, include any occasional or over the counter medications. Please put name, dosage/strength, and frequency of each medication. If you have a copy of your medication list on your computer, please print it and bring it with you.

ALLERGIES

Please list allergies to you have to any medications and non-medications, please include the reaction you had.

_____ _____

Provider Signature Date