Patient Medical History

Today's date: ____________ Name: ____________________________ Date of Birth: ______________

Referring Doctor: ________________________________ Phone: ______________________________

Family Doctor: ________________________________ Phone: ______________________________

Your preferred pharmacy: _______________________ Phone: ___________________

Major Medical Problems: Please list all past and present significant medical problems.

Medical Problem / Date	Medical Problem / Date

Surgery: Please list all past surgical procedures.

Surgery / Date	Surgery / Date

Medications: Please list all current medications, including vitamins and over the counter medications:

Medication / Dosage / Frequency	Medication / Dosage / Frequency

Allergies: No _____ Yes _____ List all allergies (food, environmental, and medications).

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PLEASE TURN OVER

Name:________________________ Today's date: ________________________

Please circle or check any that apply to you

Gastrointestinal
- o Heartburn
- o Nausea
- o Difficulty swallowing
- o Blood in Stools
- o Persistent diarrhea
- o Persistent constipation
- o Diagnosed with C-Diff ___________
- o Diagnosed with MRSA ___________
- o Colonoscopy (Date)___________
- o EGD (Date)_______________

Gastroenterologist: ______________

Heart and Lungs
- o Short of breath with mild exercise
- o Chest pain with exercise
- o Palpitations or irregular heartbeat
- o History of coronary artery disease
- o History of valvular heart disease
- o Asthma or COPD
- o Sleep Apnea

Cardiologist: ____________________

Urinary
- o Blood in urine
- o Difficulty controlling your urine
- o Difficulty urinating
- o Burning while urinating
- o Frequent Urination

Urologist: ____________________

Eye, Ear, Nose, Throat
- o Glaucoma
- o Sinus problems
- o Hoarseness
- o Frequent nosebleeds
- o Earache

Women
- o Irregular periods
- o Excessive bleeding
- o Currently pregnant

Endocrine
- o Diabetes
- o Thyroid
- o Other ________________

General
- o Poor appetite
- o Weight Loss amount: __________
- o Flu vaccine *this season*
  __No __Yes
- o Pneumovax vaccine (if over 65)
  __No __Yes
- o Have you fallen in the last 6 months?
  __ no __yes when___________
- o History of blood cots / phlebitis
- o Excessive bleeding or bruising

Social Habits
- o Do you smoke? ___________
- o Did you ever smoke?
  date stopped: ___________
- o Drink more than one alcoholic beverage per day? ________

Family History (mother, father, siblings, children)
- o Cancer
  type: ____________________
- o Heart Disease
- o Blood clots / bleeding disorders
- o Heartburn / reflux / hiatal hernias
- o Other family diseases:
  ____
  ____
  ____
  ____
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