

Medical History Sheet

Patient Name: _____ **Date of Birth:** _____

General Physician: _____ **Referring Physician:** _____

Reason for Today's Visit: _____

Medical History: (please mark all you have ever been treated for or are currently being treated)

No Medical History

General

- Bleeding Disorder
- Glaucoma
- HIV/AIDS
- MRSA
- Rheumatic Fever
- Systemic Lupus Erythematosus
- Transplant Recipient, Organ: _____

Cardiovascular

- Aortic Abnormality: _____
- Atrial Fibrillation
- Blood Transfusion, Date: _____
- Congestive Heart Failure
- Coronary Artery Disease
- Clot in Leg or Lung
- Heart Attack
- Heart Murmur
- Heart Valve Disorder, Type: _____
- High Blood Pressure

Endocrine/Metabolic

- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Low Testosterone

Respiratory

- Asthma
- COPD
- Emphysema
- Sleep Apnea
 - Use CPAP

Gastrointestinal

- Acid Reflux/GERD
- Crohn's Disease
- Hepatitis
- Stomach Ulcer
- Ulcerative Colitis

Genitourinary

- Chronic Kidney Disease
- Genital Herpes
- Genital Warts
- Interstitial Cystitis
- Kidney Stones
- Renal Failure
- STD: _____
- Urinary Tract Infections

Men's Health

- BPH
- Hydrocele/Spermatocele
- Prostatitis

Women's Health

- Endometriosis
- Uterine Fibroids

Musculoskeletal

- Arthritis
- Artificial Joints
- Chronic Back Pain
- Fibromyalgia
- Gout

Neuro/Psych

- Alzheimer's Disease
- Anxiety
- Parkinson's Disease
- Multiple Sclerosis
- Psychiatric Diagnosis: _____
- Spinal Cord Injury, Level: _____
- Stroke/TIA

Cancer

- Bladder
- Colon/Rectal
- Female, Type: _____
- Kidney
- Penile
- Prostate
- Testicular
- Other: _____

Other Medical History: _____

Immunizations:

Is the patient up to date on immunizations? Yes No

Female Health History:

Date of Last Menstrual Period: _____ Post-Menopausal: Yes No
Pregnancies# _____ Live Births# _____ Abortions (elective or spontaneous)# _____

Male Health History:

Date of Last PSA: _____
Date of Last Prostate Exam: _____ Normal _____ Abnormal _____

Recent Studies or Labs:

What: _____ Where: _____ Date: _____
What: _____ Where: _____ Date: _____

Surgical History: (please list ALL surgeries you have ever had) *if additional space needed, please ask.

Vasectomy Date: _____ Hysterectomy Date: _____

_____ Date: _____
_____ Date: _____
_____ Date: _____

Family History: (please list type of cancer) *if additional space needed, please ask

Condition	Relative(s)	Age of Diagnosis	Living/Passed
Cancer:			
Cancer:			
Diabetes			
Heart Attack			
Heart Disease			
High Blood Pressure			
Kidney Stones			
Kidney Failure			
Other:			

Social History: (circle or fill in appropriate response)

Marital Status:

___ Single ___ Divorced # of Children: _____
___ Married ___ Widowed

Current Alcohol Consumption: No Yes _____ drink per day
History of Alcohol Abuse: No Yes _____ days/months/years sober

Current Tobacco Use: No Yes cigarettes/cigars/chew _____ packs per day
History of Tobacco Use: No Yes Age start? _____ Age stop? _____

Recreational Drug Use:

___ None ___ Current, name substance(s) _____
___ Former, name substance(s) _____ _____ days/mos/yrs sober

Daily Fluid Intake:

_____ 8 oz. cups of coffee per day _____ 8 oz. glasses of tea per day

_____ 8 oz. glasses of milk per day

_____ 8 oz glasses of water per day

Patient Signature: _____ **Date:** _____

Nurse/MA Signature: _____ **Date:** _____