

Today's Date _____ Patient Name _____ Date of Birth: _____

Previous PCP: _____ Date of Last Physical Exam _____

Durable Medical Equipment?: _____ DME Company: _____

Specialists: _____

Personal Medical Health History

Conditions: Please check conditions you currently have or have had in the past:

- | | | |
|--|---|---|
| <input type="checkbox"/> Recent Colonoscopy | <input type="checkbox"/> Cancer / Personal History:
CA Type: _____
CA Type: _____
CA Type: _____ | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Recent PSA? Normal or Abnormal? | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Attach (MI) |
| <input type="checkbox"/> Abnormal Liver Enzymes | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Abnormal Pap Smears | <input type="checkbox"/> Cholecystitis | <input type="checkbox"/> Hepatitis? Type: _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> HIV Positive or AIDS |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Hodgkin's Lymphoma |
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Dentures | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Arthritis / Joint Pain _____ | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Artificial Jnt/Prosthesis _____ | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Pacemaker (Date: _____) |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Ear Infections, Chronic | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bladder or Kidney Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke / TIA (Weakness?) |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Bloody/Tarry Stools | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Bone Infection | <input type="checkbox"/> Gout | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bowel/Stomach Problems | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bronchitis, Chronic | | <input type="checkbox"/> _____ |

List Previous Surgeries including Biopsies and Endoscopies (Type and Date)		
1.		
2.		
3.		
4.		
5.		
6.		
Date of Last Screenings:		
Pap: _____	Mammogram: _____	Bone Density: _____
PSA: _____	Colonoscopy: _____	Complete Bloodwork: _____
Occupation (if retired, occupation before retirement): _____		
Education Level: _____	Difficulty Reading? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Social History - Do you?			
<input type="checkbox"/> Smoke	# packs per day:	# years:	<input type="checkbox"/> Quit? When did you quit?
<input type="checkbox"/> Drink alcohol	# drinks per day/week	<input type="checkbox"/> Recreational drug use	
<input type="checkbox"/> Victim of abuse/neglect			

Family History				
Relative	Age/Living	Age/Year of Death	Chronic Illness	Cause of Death
Grandmother (maternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandfather (paternal)				
Mother				
Father				
Sister(s)				
Brother(s)				
Children				

Current Medications (including over-the-counter)		
Drug name	Dose	Time of day taken

Medication Allergies	Vaccines
Include Drug Name and Reaction	Flu: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Pneumonia: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Shingles: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
<input type="checkbox"/> No Known Allergies	Tetanus: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Other:

Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Patient Signature: _____ Today's Date: _____