PATIENT MEDICAL HISTORY

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to anyone except when you have authorized us to do so or by law.

NAME: _____ AGE: _____ DOB: _____
First Middle Last

Reason for today's visit? _____

How long have you had this problem? _____ TODAY'S DATE: _____

ILLNESSES

Have You Ever Had:	No	Yes
Diabetes (sugar)	❑	❑
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Heart Failure	❑	❑
Rheumatic Fever with Heart Disease	❑	❑
Tuberculosis	❑	❑
Asthma/Other Lung Condition	❑	❑
Kidney Disease/Stones	❑	❑
Arthritis	❑	❑
Anemia	❑	❑
Jaundice	❑	❑
Seizures	❑	❑
Colitis/Other Bowel Disease	❑	❑
Gonorrhea/Syphilis	❑	❑
Stroke/Other Nerve Problem	❑	❑
Cancer	❑	❑
Thyroid Problems	❑	❑
Blood Transfusions	❑	❑
Mental Illness	❑	❑
Depression	❑	❑

INJURIES

Have You Ever Had Any:	No	Yes
Broken or Cracked Bones	❑	❑
Sprains	❑	❑
Lacerations (Cuts Requiring Stitches)	❑	❑
Dislocations	❑	❑
Concussion or Head Injuries	❑	❑
Have you ever been knocked unconscious?	❑	❑

HOSPITALIZATIONS

List Dates and Diagnosis:

_____

_____

_____

SURGERIES

List Dates and Diagnosis:

_____

_____

_____

	No	Yes
Have you ever been advised to have which was not done?	❑	❑

ALLERGIES

Are You Allergic To:	No	Yes
Penicillin	❑	❑
Sulfa	❑	❑
Aspirin	❑	❑
Codeine	❑	❑
Morphine	❑	❑
Other Antibiotics	❑	❑
Merthiolate/Iodine	❑	❑
Any Other Drugs	❑	❑
Any Foods	❑	❑
Environmental Allergies	❑	❑

Other Allergies: _____

_____

_____

_____

Present Weight: _____ lbs. 1 Year Ago: _____ lbs.

Present Height: _____

SOCIAL HISTORY

	No	Yes
Alcohol Use	❑	❑
How Much? _____		
Tobacco Use	❑	❑
How Much? _____		
What Type? _____		
How Many Years? _____		

Types of Jobs (current and past)

_____

_____

_____

List Any Travel and Dates occurring outside Georgia (Southeast USA)

_____

_____

_____

RECENT MEDICAL COMPLAINTS

Do You Now Have Or Have You Had Within The Last Year:	No	Yes
Frequent or Severe Headaches	❑	❑
Fainting Spells	❑	❑
Dizziness	❑	❑
Loss of Consciousness	❑	❑
Hearing or Ear Problems	❑	❑
Nose Bleeds/Bleeding Gums	❑	❑
Swallowing Problems/Hoarseness	❑	❑
Double Vision/Blurred Vision	❑	❑

[OVER]

PATIENT MEDICAL HISTORY (Continued)

NAME: _____ AGE: _____ DOB: _____
First Middle Last

RECENT MEDICAL COMPLAINTS (con't)

Do You Now Have Or Have You Had Within The Last Year:

	No	Yes
Swollen Glands	❑	❑
Shortness of Breath	❑	❑
Chest Pain/Pressure	❑	❑
Fluttering In Chest	❑	❑
Abdominal Pain	❑	❑
Diarrhea/Constipation	❑	❑
Bloody Stools/Change In Stools	❑	❑
Weakness or Numbness	❑	❑
Pain or Frequent Urination	❑	❑
Difficulty Starting To Urinate	❑	❑
Do you get up at night to urinate?	❑	❑
How many times? _____		
Is this more or less than before? _____		
Any Blood In Urine	❑	❑
Lose Urine on Coughing/Sneezing	❑	❑
Swelling/Pain in Joints?	❑	❑
Which ones? _____		
Rashes/Moles That Have Changed	❑	❑
Seizures	❑	❑
Mental Illness/Depression	❑	❑

IMMUNIZATIONS

	No	Yes
Tetanus Shots	❑	❑
Pneumovax (Date: _____)	❑	❑
Other: _____		

PRESENT MEDICATIONS

Name of Drug	Dosage	How Many/Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

WOMEN ONLY—MENSTRUAL HISTORY

Age At Onset _____
Regular? Yes❑ No ❑
Cycle ____Days (start to start)
Flow: Heavy❑ Med❑ Light❑
# of Pads? _____
Any Clots Passed? Yes❑ No ❑
Pain or Cramps? Yes❑ No ❑
Date of Last Period?_____
Last Pelvic Exam?_____
Last Pap Smear?_____
Results: Neg❑ Pos ❑
Any Vaginal Discharge?
❑Yes, Color _____
❑No

Vaginal Itching? Yes❑ No ❑
PREGNANCIES—How many:
Children Born Alive _____
Stillborn _____
Premature _____
Cesarean _____
Miscarriages _____
Complications with Pregnancies?
_____
_____
_____

Birth Control Pills ❑Yes ❑No
How Long Taken? _____

FAMILY MEDICAL HISTORY

		IF LIVING Age	IF LIVING Health	IF DECEASED Age At Death	IF DECEASED Cause	PLEASE CIRCLE Has any blood relative ever had:	No or Yes		Who
FATHER						CANCER	NO	YES	
MOTHER						TUBERCULOSIS	NO	YES	
BROTHER OR SISTER	1.					DIABETES	NO	YES	
	2.					HEART TROUBLE	NO	YES	
	3.					HIGH BLOOD PRESSURE	NO	YES	
	4.					STROKE	NO	YES	
	5.					EPILEPSY	NO	YES	
HUSBAND OR WIFE						LIVER DISEASE	NO	YES	
SON OR DAUGHTER	1.					KIDNEY DISEASE	NO	YES	
	2.					ARTHRITIS	NO	YES	
	3.					ASTHMA	NO	YES	
	4.					ALCOHOLISM	NO	YES	
	5.					BLOOD DISORDER	NO	YES	
	6.					OTHER CONDITION:			
	7.								
	8.								