



MEDICAL & FAMILY HISTORY FORM

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

Chief Complaint — _____

Referring Physician Name — _____

Medications — Please list all of your current prescription and non-prescription medications, vitamins and supplements:

<input type="checkbox"/> None	Medication Name	Dosage

Allergies

None Penicillin Sulfa Aspirin Iodine Latex Others: _____

Past Medical History

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Barrett's Esophagus
<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic anxiety
<input type="checkbox"/> Chronic sinusitis
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Colon cancer | <input type="checkbox"/> Colon polyps
<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Constipation
<input type="checkbox"/> COPD
<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Fatty liver
<input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Gastritis
<input type="checkbox"/> GERD (Reflux)
<input type="checkbox"/> GI Bleeding
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hiatal hernia
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> HIV or AIDS
<input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Kidney disease/failure
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Neurologic Disorders
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Ovarian cyst
<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Peptic ulcer
<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Sciatica
<input type="checkbox"/> Seizures
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Stroke
<input type="checkbox"/> TB (Tuberculosis)
<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Valvular Heart Disease |
|--|---|--|---|--|

Previous Hospitalizations

Reason	Date	Reason	Date

Surgeries/Procedures

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Appendectomy
<input type="checkbox"/> Barium Enema
<input type="checkbox"/> Breast Surgery
<input type="checkbox"/> Capsule Endoscopy
<input type="checkbox"/> Cholecystectomy
<input type="checkbox"/> Colon surgery
<input type="checkbox"/> Colonoscopy
<input type="checkbox"/> Colostomy | <input type="checkbox"/> C-section
<input type="checkbox"/> CT Scan
<input type="checkbox"/> EGD
<input type="checkbox"/> ERCP
<input type="checkbox"/> Gallbladder Surgery
<input type="checkbox"/> Heart bypass
<input type="checkbox"/> Heart valve Replacement
<input type="checkbox"/> Hemorrhoid surgery | <input type="checkbox"/> Hiatal hernia repair
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Joint replacement
<input type="checkbox"/> Kidney Surgery
<input type="checkbox"/> Liver biopsy
<input type="checkbox"/> MRI
<input type="checkbox"/> Obesity surgery
<input type="checkbox"/> Ovarian Surgery | <input type="checkbox"/> Pacemaker Placement
<input type="checkbox"/> Prostate (TURP)
<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Sigmoidoscopy
<input type="checkbox"/> Small Bowel Resection
<input type="checkbox"/> Stomach Surgery
<input type="checkbox"/> Thyroid Surgery | <input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Tubal ligation
<input type="checkbox"/> Ulcer Surgery
<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Upper GI Series X-ray
<input type="checkbox"/> Uterine Surgery
<input type="checkbox"/> None |
|---|---|--|--|---|

Other _____

Family History

	Father	Mother	Brothers/Sisters
Healthy/Alive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Marital status married single divorced widowed
 Occupation: _____ unemployed retired
 Smoking history: never yes; _____ packs per day for _____ years; Quit (how long) _____
 Other tobacco use no yes; details: _____
 Alcohol use no yes; amount per day: _____ for _____ years
 Drug use no yes; specify drugs and amounts: _____
 Exercise habits no yes; how much and how often: _____
 Recent travel outside US no yes; where: _____
 Caffeine use no yes

Review of Systems – check all that apply at the present time

General <input type="checkbox"/> chills <input type="checkbox"/> fever <input type="checkbox"/> loss of appetite <input type="checkbox"/> night sweats <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <input type="checkbox"/> feeling tired or poorly Eyes <input type="checkbox"/> worsening vision <input type="checkbox"/> blurred vision <input type="checkbox"/> vision distortion <input type="checkbox"/> eye pain Otolaryngeal Symptoms <input type="checkbox"/> earache <input type="checkbox"/> nasal discharge <input type="checkbox"/> mouth sores <input type="checkbox"/> bleeding gums <input type="checkbox"/> hoarseness <input type="checkbox"/> throat pain <input type="checkbox"/> facial pain <input type="checkbox"/> sinus pain Cardiovascular <input type="checkbox"/> chest pain/discomfort <input type="checkbox"/> fast heart rate <input type="checkbox"/> swelling of legs <input type="checkbox"/> varicose veins	Respiratory <input type="checkbox"/> chronic cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath Gastrointestinal <input type="checkbox"/> abdominal swelling <input type="checkbox"/> abdominal pain <input type="checkbox"/> belching <input type="checkbox"/> black stools <input type="checkbox"/> red blood in bowel movement <input type="checkbox"/> change in bowel movement frequency <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> fatty food intolerance <input type="checkbox"/> full after eating small meals <input type="checkbox"/> gas/bloating <input type="checkbox"/> heartburn <input type="checkbox"/> hemorrhoids <input type="checkbox"/> yellow skin or eyes <input type="checkbox"/> nausea <input type="checkbox"/> pain with swallowing <input type="checkbox"/> decrease in appetite <input type="checkbox"/> rectal bleeding <input type="checkbox"/> rectal pain <input type="checkbox"/> regurgitation of food <input type="checkbox"/> incontinence of stool <input type="checkbox"/> vomiting <input type="checkbox"/> vomiting blood	Musculoskeletal <input type="checkbox"/> joint pain <input type="checkbox"/> joint stiffness <input type="checkbox"/> swollen joints <input type="checkbox"/> low back pain <input type="checkbox"/> muscle pain Skin Symptoms <input type="checkbox"/> Pruritis (itching) <input type="checkbox"/> skin lesions <input type="checkbox"/> rashes Neurologic <input type="checkbox"/> numbness or tingling <input type="checkbox"/> dizziness/lightheadedness <input type="checkbox"/> vertigo <input type="checkbox"/> headaches <input type="checkbox"/> weakness in arms or legs <input type="checkbox"/> blurred vision <input type="checkbox"/> memory lapses or loss Psychiatric <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> panic attacks <input type="checkbox"/> loss of sleep	Endocrine <input type="checkbox"/> heat or cold intolerance <input type="checkbox"/> excessive thirst or urination <input type="checkbox"/> hot flashes Hematologic/Lymphatic <input type="checkbox"/> easy bruising tendency <input type="checkbox"/> swollen glands <input type="checkbox"/> nosebleeds Urinary <input type="checkbox"/> pain or difficulty with urination <input type="checkbox"/> frequent urination <input type="checkbox"/> blood in urine <input type="checkbox"/> incontinence of urine Genitoreproductive - Female <input type="checkbox"/> vaginal discharge <input type="checkbox"/> heavy periods date of last period: _____ Genitoreproductive - Male <input type="checkbox"/> discharge from penis <input type="checkbox"/> testicular pain <input type="checkbox"/> testicular lump
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