Quality Care with a Personal Touch

MEDICAL HISTORY FORM - Page 2 of 2

Name: _____ Exercise: _____ Sleep: _____hrs/night Seat belt use? _____

Alcohol: _____ drinks per week Cigarettes per day: _____ when started? _____ when quit? _____

Calcium/milk intake: _____ glasses per day Aspirin: _____/day Breast/testicle self-exam: _____

Vaccinations: Last tetanus shot: _____ Pneumonia Vaccination: _____ Hepatitis B Series: _____

CURRENT MEDICAL CONCERNS/QUESTIONS: _____

HEALTH QUESTIONNAIRE: PLEASE CHECK ALL THAT APPLY

- ☐ Headaches
- ☐ Visual Difficulties
- ☐ Hearing Difficulties
- ☐ Earaches

- ☐ Breathing Problems
- ☐ Cough
- ☐ Asthma/Emphysema
- ☐ Shortness of Breath
- ☐ Snoring

- ☐ Sleep Apnea

- ☐ Digestive Disturbances
- ☐ Abdominal Pain
- ☐ Reflux/Heartburn
- ☐ Ulcers
- ☐ Gas
- ☐ Change in Stool
- ☐ Rectal Bleeding
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel
- ☐ Last Sigmoidoscopy _____
- ☐ Last Colonoscopy _____

- ☐ Neurological Disorder
- ☐ Seizures
- ☐ Dizziness
- ☐ Passing Out
- ☐ Numbness
- ☐ TIA
- ☐ Stroke
- ☐ Tremor/Shakiness
- ☐ Memory Loss
- ☐ Weakness
- ☐ Neuropathy

- ☐ Dental Problems
- ☐ Allergies
- ☐ Swollen Lymph Glands

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pain/Pressure/Angina
- ☐ Murmur
- ☐ Rapid or Irregular Heart Beat

- ☐ Your Cholesterol _____

- ☐ Urinary Incontinence
- ☐ Bladder Infections
- ☐ Burning on Urination
- ☐ Urinary Urge/Frequency
- ☐ Weakness of Urinary Stream

- ☐ **MEN:**
- ☐ Penile Discharge
- ☐ Sexual Difficulties
- ☐ Prostate Disorder
- ☐ Number of Children _____

- ☐ **WOMEN:**
- ☐ Pregnancies _____
- ☐ Number of Children _____
- ☐ Number of Miscarriages _____
- ☐ Number of Abortions _____
- ☐ Sexual Difficulties
- ☐ Painful/Irregular Periods
- ☐ Last Mammogram _____
- ☐ Last Pap _____
- ☐ Menopausal Symptoms
- ☐ Breast Lumps
- ☐ Date of Last Menstrual Period _____

- ☐ Weight Change/Concern
- ☐ Diabetes
- ☐ Fevers/Night Sweats
- ☐ Anemia/Bleeding

- ☐ Skin Problems
- ☐ Rash
- ☐ Worrisome Moles
- ☐ Warts
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Cancer

- ☐ Depression
- ☐ Suicidal Thoughts
- ☐ Chronic Fatigue
- ☐ Psychiatric Illness
- ☐ Difficulty Sleeping
- ☐ Anxiety/Nervousness
- ☐ Hard Drugs/Marijuana

- ☐ Stress
- ☐ Family/Marital Issues
- ☐ Pushed/Shoved/Harmed?
- ☐ Domestic Violence
- ☐ Counseling

- ☐ Muscle Pain
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Broken Bones
- ☐ Osteoporosis
- ☐ Foot Swelling
- ☐ Gout
- ☐ Advance Directives
- ☐ Living Will
- ☐ Power of Attorney

☐ Personal Goals for following year: _____
