CONFIDENTIAL MEDICAL HISTORY

NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

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Please answer *all* questions. If you do not know the answer, or do not understand the question, insert a question mark in the space. *Please leave no blanks*. No part of this form's contents will be released without your signed consent.

CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began:

	Problem(s)	Date of Onset
1		
2		
3		
4		
5		

GENERAL HEALTH

Do you consider yourself basically healthy now? Yes ☐ No ☐ Have you been well most of your life? Yes ☐ No ☐

When did you last feel well?_____

How is your overall "pep" now compared with a year ago? Increased ☐ Decreased ☐ About the same ☐

Has there been a *net* change in your weight in the past year (If so, indicate gain or loss)_____

Have you been having fever lately? Yes ☐ No ☐

Do you usually sleep well? Yes ☐ No ☐; If yes, how many hours per night?_____

Have you been followed by a physician on a regular basis? Yes ☐ No ☐; Name & Address_____

_____

Do you regularly use your seatbelt? Yes ☐ No ☐

What do you do in your spare time?_____

How many hours/week do you watch TV?_____

In the past year, has there been any change in your: Marital status?_____ Work or job?_____

Residence?_____ Spare time activity?_____ Physical activity?_____ Drinking habits?_____

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete: Consult family, friends, physicians, etc.)

Operation	Hospital + City	Date

Have you ever been seriously injured? (If so, give details.)_____

List chronologically all hospitalizations not already mentioned (do not include obstetrical admissions):

Reason for Hospitalization	Hospital + City	Date

Have you ever been seriously ill otherwise? (If so, give details.)_____

Have you ever had any of the following?

Thyroid disease_____ Anemia_____ Diabetes_____ Bleeding tendency_____

Cancer_____ Venereal disease_____ Alcoholism_____ Drug dependence_____

Blood transfusion_____ AIDS_____ Any obscure or unusual disease_____

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

RESPIRATORY

Have you ever had any of the following? (If so, indicate when.)
- Pneumonia ____
- Acute bronchitis ____
- Chronic bronchitis ____
- Pleurisy ____
- Tuberculosis ____
- Asthma ____
- Emphysema ____
- Pulmonary embolism ____
- Other lung trouble ____

Have you ever coughed up blood? ____

Do you often or regularly:
- Cough? ____
- Raise sputum? ____

Do you often get colds? ____

Do your colds tend to " go to" or "settle" in your chest? ____

Do you currently smoke cigarettes? ____
- How many a day? ____
- How long have you smoked? ____

Did you formerly smoke cigarettes? ____
- How many a day? ____
- When did you quit? ____

When was your last chest x-ray? ____

Have you ever had an abnormal chest x-ray? ____

CIRCULATORY

Have you ever had any of the following? (If so, indicate when.)
- Heart trouble ____
- Heart murmur ____
- Heart attack (myocardial infarction) ____
- Angina Pectoris ____
- High cholesterol ____
- High blood pressure ____
- Rheumatic fever ____
- Palpitations ____
- Congestive heart failure ____
- An abnormal electrocardiogram ____
- An exercise stress test ____
- An echocardiogram ____
- Heart by-pass surgery ____
- Coronary angioplasty ____
- Leg cramps while walking ____
- Exercise-limiting shortness of breath ____

Have you ever taken digoxin? ____

Have you ever taken nitroglycerine? ____

Have you ever taken water pills? ____

DIETARY HABITS

(Indicate # servings per week)

MEAT GROUP:
- Red Meats ____
- Pork ____
- Fish ____
- Chicken ____

DAIRY PRODUCTS:
- Eggs (#/wk) ____
- Whole Milk ____
- 2% Fat Milk ____
- Skim Milk ____
- Cheese ____
- Ice Cream ____
- Yogurt (Regular or Frozen) ____
- Butter ____
- Margarine ____

FRUITS:
- Fresh ____
- Canned ____

VEGETABLES:
- Fresh ____
- Canned ____

CARBOHYDRATES:
- Pasta ____
- Bread ____
- Cereal ____
- Beans ____
- Table Sugar ____

BEVERAGES:
- Regular Coffee ____
- Decaf Coffee ____
- Tea ____
- Decaf Tea ____
- Regular Sodas ____
- Decaf Sodas ____
- Diet Sodas ____
- Alcohol ____
- Beer (# cans) ____
- Wine (# glasses) ____
- "Hard" (# shots) ____

DESSERTS:
- Cakes, Pies ____
- Candy ____

Do you read labels? ____

Do you add salt to your food? ____

Do you take vitamins? ____

DIGESTIVE

Do you often or regularly have:
- Trouble swallowing ____
- "Heartburn" ____
- Food "repeating" ____
- Nausea or vomiting ____
- Abdominal pain ____
- Constipation ____
- Diarrhea ____

Has there been any change in your appetite in the last six months? ____

Has there been any change in the way your bowels function in the last six months (*regardless* of whether or not they function normally)? ____

Have you ever had any of the following? (If so, indicate when.)
- Ulcer (stomach or duodenal) ____
- Hiatal hernia ____
- Vomiting of blood ____
- Black or tarry stools ____
- Yellow skin (jaundice) ____
- Liver trouble ____
- Gallbladder trouble or stones ____
- Pancreatitis ____
- Persistent diarrhea ____
- Colitis or dysentery ____
- Diverticulitis ____
- Blood in your stool ____
- Hemorrhoids ____
- Hernia ____
- Other digestive disease ____
- Abdominal surgery ____

Have you ever had x-rays of your:
- Stomach (GI series) ____
- Gallbladder ____
- Bowel (Barium enema) ____

MUSCULO-SKELETAL

Have you ever had any of the following? (If so, indicate when.)
- A disk problem ____
- Sciatica ____
- Swelling of joint(s) (osteo arthritis) ____
- Rheumatoid arthritis ____
- Gout ____
- Bursitis ____
- Skin disorder (e.g., psoriasis, eczema) ____

REVIEW OF SYSTEMS

Answer all *questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!*

URINARY

Have you ever had or been told you had any of the following? (If so, indicate when.)

- Nephritis or nephrosis _____
- Kidney disease _____
- Protein or albumin in urine _____
- Blood or pus in urine _____
- Urine or kidney stones _____
- Difficulty with urinary stream _____
- Bladder trouble _____
- Prostate trouble _____
- Prostate surgery _____
- Impotence _____

How many times do you get up at night to urinate? _____

OBSTETRIC & GYNECOLOGICAL

Have you ever had tumor(s), cyst(s), or other breast disease? _____

Have you ever had a mammogram? _____

How many times have you been pregnant (including miscarriages)? _____

How many live births? _____

Do you ever bleed ("spot") between periods or after intercourse? _____

Do your periods ever last longer than you expect? _____

Do you get yearly pap smears? _____

Have you ever had toxemia? _____

Have you had a hysterectomy? _____

Have you had any other surgery of your female organs? _____

Are you now taking hormones or birth control pills? _____

Do you smoke cigarettes? _____

If you are still menstruating...

What is the date of:

- You last period? _____
- The one before? _____

How many days do your periods usually last? _____

Are your periods regular? _____

What is your cycle length? _____

If you've had your change of life...

When was your last period? _____

Have you bled since? _____

EXERCISE

Do you exercise regularly? _____

How many times/wk? _____

How long is an average exercise session? _____

Do you...

- Walk _____
- Jog _____
- Run _____
- Row _____
- Bike _____
- Use a bike helmet _____
- Swim _____
- Ski downhill _____
- Ski cross country _____
- Dance (type) _____
- Use an exercise bike _____
- Do aerobics _____
- Do calisthenics _____
- Lift weights _____
- Play golf _____
- Use a golf cart _____
- Play tennis _____
- Play racquetball/handball _____
- Surf _____

If you walk, jog, bike, etc., how fast & how far?

_____

_____

_____

_____

Do you get any unusual symptoms when you exercise (i.e., lightheadedness, chest pain or pressure, leg pain, severe shortness of breath)? Yes ☐ No ☐

(Describe)

_____

_____

_____

_____

_____

NEUROLOGICAL

Have you ever had any of the following? (If so, indicate when.)

- Frequent or recurrent headaches _____
- Migraine headaches _____
- Loss of consciousness _____
- Convulsions or seizures _____
- A head injury _____
- Stroke _____
- Paralysis _____
- Uncontrollable movements _____
- Parkinson's Disease _____
- Difficulty with speech _____
- Double vision _____
- Numbness _____
- Hallucinations _____
- Nervous breakdown _____
- Severe depression or nervousness _____
- Crying spells _____
- Other Psychiatric condition _____

EYES, EARS, NOSE, THROAT

Have you ever had:

- Eye surgery _____
- Glaucoma _____
- Other major eye disease (specify) _____
- Deafness _____
- Abnormal noises in the ear _____
- Nose or throat surgery _____

ALLERGIES

Have you ever had:

- Hives _____
- Asthma _____
- Hay fever _____
- Other allergies _____

Have you ever had a bad reaction to penicillin or any other drug (e.g., rash, itching, swelling, etc.)? (If so, give name of drug and kind of reaction) _____

_____

_____

CURRENT MEDICATIONS

List all the medications you are now taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list MUST be detailed, accurate, and complete; therefore, consult with your family, druggist, physician. (Do not neglect aspirin and other pain medicines; hormones; contraceptive, water, diet, nerve, or sleeping pills.)

Name of Medicine	Strength each dose	How often taken	When began taking

PERSONAL HISTORY

In what state or foreign country were you born?_____

Are you married?_____ How long?_____

Have you been married in the past?_____

How many times?_____

Do you have a pet?_____

What is your current occupation?_____

Do you enjoy your work(retirement)?_____

Have you ever worked in the field of medicine, in any capacity (including volunteer, aide, clerk, technician)?_____

How far did you go in school?_____

Name of college or graduate school_____

_____

List the areas you have lived in chronologically, giving dates:

Area	From	To

List your past occupations chronologically, giving dates:

Occupation	From	To

FAMILY HEALTH

Please give the following information about the health of your immediate family:

Relation	Age/Sex	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			
Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

Diabetes_____ Cancer_____ High blood pressure (Hypertension)_____

Rheumatoid arthritis_____ Blood disease_____ Any obscure or unusual disease_____

Thyroid disease_____ Epilepsy_____ Psychiatric disease or nervous breakdown_____

Heart attack or bypass surgery_ Alcoholism_____ A disease which "runs in the family"?_____

_____ Cholesterol problems_____ Other_____