

Name: \_\_\_\_\_

Date of Service: \_\_\_\_\_

### Medical History Form

Please mark any changes in your personal or family medical history.

#### Family Medical History

|   | No History               | Father                   | Mother                   | Brother                  | Sister                   | Son                      | Daughter                 | Other                    |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>Anemia</b>                               | <input type="checkbox"/> |
| <b>Cancer</b>                               | <input type="checkbox"/> |
| <b>CAD</b><br>(Coronary Artery Disease)     | <input type="checkbox"/> |
| <b>Diabetes Mellitus</b>                    | <input type="checkbox"/> |
| <b>Heart Disease</b>                        | <input type="checkbox"/> |
| <b>Hyperlipidemia</b><br>(High Cholesterol) | <input type="checkbox"/> |
| <b>Hypertension</b>                         | <input type="checkbox"/> |
| <b>Kidney Disease</b>                       | <input type="checkbox"/> |
| <b>Kidney Stones</b>                        | <input type="checkbox"/> |
| <b>Stroke</b>                               | <input type="checkbox"/> |

#### Social History

| Type     | Current                  | Past                     | How Much? | How Long? |
|----------|--------------------------|--------------------------|-----------|-----------|
| Tobacco  | <input type="checkbox"/> | <input type="checkbox"/> |           |           |
| Alcohol  | <input type="checkbox"/> | <input type="checkbox"/> |           |           |
| Drug Use | <input type="checkbox"/> | <input type="checkbox"/> |           |           |

For Physician Use

#### Medication History

| Current Medications | Dose (mg,mcg,units) | Times a Day | Ordering Physician |
|---------------------|---------------------|-------------|--------------------|
|                     |                     |             |                    |
|                     |                     |             |                    |
|                     |                     |             |                    |
|                     |                     |             |                    |
|                     |                     |             |                    |
|                     |                     |             |                    |
|                     |                     |             |                    |
|                     |                     |             |                    |
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|                     |                     |             |                    |

List any adverse/allergic reactions you have had to any previous medications. Specifically include any medication that caused a high potassium, cough, or your face to swell.

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### Medical History Form

The information you provide to your doctor is confidential and cannot be released without your authorization.

#### Medical Problems

- |  |                                       |  |  |   |
|--|---------------------------------------|--|--|---|
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Kidney Stones   | <input type="checkbox"/> Gout            | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> TIAs (mini stroke)  | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Prostate Disease  | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Dementia            | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Autoimmune      | <input type="checkbox"/> Transfusions   |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Emphysema    | <input type="checkbox"/> High/Low Potassium  | <input type="checkbox"/> Bowel Disease   | <input type="checkbox"/> Anemia         |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Stomach Ulcers  | <input type="checkbox"/> Blood Clots    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea  | <input type="checkbox"/> Diabetes type <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Mental Illness |
| Year of last normal BP: _____                |                                       | Year of onset: _____   |  | <input type="checkbox"/> Other Disorder |
|  |                                       | Complications:   |  | # Pregnancies ____                      |
|  |                                       | <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Nerve  |  | # Deliveries ____                       |

For Physician Use  
Mental Illness

#### Hospitalizations

Please list all of your previous visits to the hospital, include ER visits and surgeries.

| Reason for Hospitalization | Date | For physician use |
|----------------------------|------|-------------------|
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |
|                            |      |                   |

For physician use

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## Interim Health Report

Please mark any changes in your personal or family medical history.

### Family, Past, and Social History

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Hospitalizations/Surgery: \_\_\_\_\_

If you have diabetes: When was your last eye appointment? \_\_\_\_\_

When was your last foot exam? \_\_\_\_\_

If you are 50 years old or older when was your last colonoscopy? \_\_\_\_\_

New Medical Problems or Tests: \_\_\_\_\_

New Medications: \_\_\_\_\_

Deaths or illnesses in your family: \_\_\_\_\_

Last menstrual period or change in menses: \_\_\_\_\_

How much exercise do you get? \_\_\_\_\_

If you are getting iron infusions when was your last infusion? \_\_\_\_\_

### Review of Systems

Have you experienced any of the following symptoms (problems) (Circle Yes or No):

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#### Constitutional

|              |     |    |
|--------------|-----|----|
| Fever/Chills | Yes | No |
| Weight Loss  | Yes | No |

#### Eyes

|                |     |    |
|----------------|-----|----|
| Visual Changes | Yes | No |
| Pain           | Yes | No |

#### Allergic/Immunologic

|                |     |    |
|----------------|-----|----|
| Hay Fever      | Yes | No |
| Drug Allergies | Yes | No |

#### Endocrine

|                       |     |    |
|-----------------------|-----|----|
| Heat/Cold Intolerance | Yes | No |
| Tired or Sluggish     | Yes | No |

#### Heart & Blood Vessels

|                      |     |    |
|----------------------|-----|----|
| Chest Pain           | Yes | No |
| Heart Skip a Beat    | Yes | No |
| Swelling of the Legs | Yes | No |

#### Neurological

|                   |     |    |
|-------------------|-----|----|
| Dizziness         | Yes | No |
| Numbness/Tingling | Yes | No |

#### Psychological

|                       |     |    |
|-----------------------|-----|----|
| Do you feel hopeless  | Yes | No |
| Do you feel depressed | Yes | No |

#### Gastrointestinal

|                       |     |    |
|-----------------------|-----|----|
| Belly Pain            | Yes | No |
| Diarrhea/Constipation | Yes | No |
| Nausea or Vomiting    | Yes | No |

#### Skin

|         |     |    |
|---------|-----|----|
| Rash    | Yes | No |
| Itching | Yes | No |

#### Joints & Muscles

|                        |     |    |
|------------------------|-----|----|
| Joint, back, neck Pain | Yes | No |
| Muscle Pain            | Yes | No |

#### Hematological

|                   |     |    |
|-------------------|-----|----|
| Bruising/Bleeding | Yes | No |
| Transfusions      | Yes | No |

#### Ear, Nose & Throat

|                    |     |    |
|--------------------|-----|----|
| Ear/Throat Pain    | Yes | No |
| Difficulty Hearing | Yes | No |
| Sinus Trouble      | Yes | No |

#### Bladder and Urination

|                           |     |    |
|---------------------------|-----|----|
| Difficulty urinating      | Yes | No |
| Incontinence              | Yes | No |
| Urinary frequency         | Yes | No |
| Abnormal vaginal bleeding | Yes | No |

#### Respiratory

|                     |     |    |
|---------------------|-----|----|
| Wheezing            | Yes | No |
| Cough               | Yes | No |
| Shortness of breath | Yes | No |
| Loud snoring        | Yes | No |

\_\_\_\_\_  
For physician use