

# MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **PLEASE PRINT AND COMPLETE ALL INFORMATION.**

Case No.	<b>MEDICAL HISTORY RECORD</b> All information is treated as confidential unless you grant permission to release it. <b>PLEASE PRINT AND COMPLETE ALL INFORMATION.</b>			Today's Date	
Medicare No.				Birthdate	
Medicaid No.				Male <input type="checkbox"/> Female <input type="checkbox"/>	
Last Name		First	Middle	Daytime Phone	Home Phone
Address		City	State	Zip	Occupation
Person to notify in emergency		Daytime Phone		Relationship	Last Physical Examination Date
By Doctor		Phone		Family or Referring Doctor	Phone No.

May I contact Either of These Doctors For You Past Health Records? Yes  No  What are your medical symptoms? \_\_\_\_\_

Family History	IF LIVING			IF DECEASED		Any blood relatives who have or have had any of the listed conditions								
	Age	HEALTH Good Fair Poor		Death Age	Death Cause	✓Yes No Relationship			✓Yes No Relationship					
Father						Asthma					Hay Fever			
Mother						Arthritis					Insanity			
Brothers (Circle sex)						Allergies					Kidney Disease			
1. M F						Anemia					Leukemia			
2. M F						Alcoholism					Migraine			
3. M F						Bleeding Tend.					Nervous Break'n			
4. M F						Cancer					Obesity			
5. M F						Colitis					Rheumatism			
Husband <input type="checkbox"/>						Congenital Heart					Rheumatic Fever			
Wife <input type="checkbox"/>						Diabetes					Stroke			
Sons (Circle sex)						Epilepsy					Suicide			
1. M F						Goiter					Stomach Ulcers			
2. M F						High Bl. Press.					Tuberculosis			
3. M F						Heart Disease								
4. M F														
5. M F														
6. M F														

<b>HABITS</b> Do you <input type="checkbox"/> Yes <input type="checkbox"/> No Smoke ..... <input type="checkbox"/> <input type="checkbox"/> Drink Coffee ..... <input type="checkbox"/> <input type="checkbox"/> Drink Alcohol ..... <input type="checkbox"/> <input type="checkbox"/> Drink Beer ..... <input type="checkbox"/> <input type="checkbox"/> Falls Asleep Easily ..... <input type="checkbox"/> <input type="checkbox"/> Awaken Early ..... <input type="checkbox"/> <input type="checkbox"/>	<b>Daily Consumption:</b> _____ Pkgs. _____ Cups _____ oz. _____ oz.	<b>MEDICATIONS</b> ✓ If Taken ✓ Blood Thinning Pills ..... <input type="checkbox"/> ✓ Iron or Poor Blood Med. <input type="checkbox"/> ✓ Vitamins ..... <input type="checkbox"/> Antacids ..... <input type="checkbox"/> Cortisone ..... <input type="checkbox"/> Laxatives ..... <input type="checkbox"/> Water Pills ..... <input type="checkbox"/> Antibiotics ..... <input type="checkbox"/> Cough Medicine ..... <input type="checkbox"/> Phenobarbital ..... <input type="checkbox"/> Weight Reducing Pills ..... <input type="checkbox"/> Aspirin, Bufferin, Anacin ..... <input type="checkbox"/> Digitalis ..... <input type="checkbox"/> Shots ..... <input type="checkbox"/> Other (list) _____ Barbiturates ..... <input type="checkbox"/> Dilantin ..... <input type="checkbox"/> Sleeping Pills ..... <input type="checkbox"/> Birth Control Pills ..... <input type="checkbox"/> Hormones ..... <input type="checkbox"/> Thyroid Med. .... <input type="checkbox"/> Blood Pressure Pills ..... <input type="checkbox"/> Insulin, Diabetic Pills ..... <input type="checkbox"/> Tranquilizers ..... <input type="checkbox"/>
---	--	---

<b>Operations you have had:</b> _____ Year _____ _____ Year _____ _____ Year _____	<b>Diseases you have had requiring hospitalization</b> _____ Year _____ _____ Year _____ _____ Year _____	<b>Serious illness not requiring hospitalization</b> _____ Year _____ _____ Year _____ _____ Year _____
--	---	---

<b>Drugs you are allergic to:</b> _____ _____ _____	<b>Describe any serious injuries or accidents you have had:</b> _____ _____ _____
--	--

<b>WOMEN only:</b> ✓ Yes No Are you having regular monthly menstrual periods? ..... <input type="checkbox"/> <input type="checkbox"/> Have you ever had bleeding between your periods? ..... <input type="checkbox"/> <input type="checkbox"/> When? _____ Do you have very heavy bleeding with your periods? ..... <input type="checkbox"/> <input type="checkbox"/> When? _____ Do you feel bloated and irritable before your period? ..... <input type="checkbox"/> <input type="checkbox"/> Are you now on or have you ever taken the birth control pill? ..... <input type="checkbox"/> <input type="checkbox"/> When? _____ Have you ever had a miscarriage? ..... <input type="checkbox"/> <input type="checkbox"/> When? _____ Have you ever had a discharge from the nipple of your breast? ..... <input type="checkbox"/> <input type="checkbox"/> When? _____ Do you regularly have the cancer test of the cervix? ..... <input type="checkbox"/> <input type="checkbox"/> Date of last test _____ How many children born alive ..... _____ How many stillbirths ..... _____ How many premature births ..... _____ Date of last menstrual period ..... _____ How many miscarriages ..... _____ How many cesarean operations ..... _____ Any complication of pregnancy? (explain) _____	<b>MEN only: Have you ever had:</b> ✓ Yes No Loss of sexual activity? For how long? ..... <input type="checkbox"/> <input type="checkbox"/> Treatment for genitals (private parts)? ..... <input type="checkbox"/> <input type="checkbox"/> Discharge from penis? ..... <input type="checkbox"/> <input type="checkbox"/> Hernia (rupture)? ..... <input type="checkbox"/> <input type="checkbox"/> Prostate trouble? ..... <input type="checkbox"/> <input type="checkbox"/>
---	---

