INITIAL MEDICAL HISTORY FORM

PATIENT NAME:		TODAYS DATE:
MEMBER ID NUMBER:	SEX: M F	BIRTHDATE:

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)
OCCUPATION	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )	

ALLERGIES AND SENSITIVITIES

List anything that you are allergic to such as certain foods, medications, dust, chemicals or soaps, household items, pollen, bee stings, etc., and indicate how each affects you.

ALLERGIC TO:	REACTION:

CURRENT MEDICAL PROBLEMS

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you.

Illness or medical problem	Physician treating you

MEDICATIONS

Please list all medication you are now taking, including those you buy without a doctor's prescription (such as aspirin or cold tablets).

1. ____	5. ____	9. ____
2. ____	6. ____	10. ____
3. ____	7. ____	11. ____
4. ____	8. ____	12. ____

ILLNESS AND MEDICAL PROBLEMS

Please mark with an (X) any of the following illnesses and medical problems you have or have not had, and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

(X)	Illness	(Year)	(X)	Illness	(Year)	(X)	Illness	(Year)
	Eye or eye lid infection			Arteriosclerosis			Epilepsy	
	Glaucoma			Heart murmur			Head injury	
	Other eye problems			Other heart condition			Stroke	
	Deafness			Stomach/duodenal ulcer			Convulsions, seizures	
	Ringing sound in ears (Tinnitus)			Diverticulosis			Arthritis	
				Colitis			Cancer tumor	
	Bronchitis			Gout			Bleeding tendency	
	Emphysema			Yellow jaundice			Diabetes	
	Pneumonia			Liver trouble			Hepatitis	
	Allergies or asthma			Gallbladder trouble			Measles	
	Tuberculosis			Hernia			Mononucleosis	
	Other lung problems			Hemorrhoids			Psoriasis	
	High blood pressure			Kidney or bladder disease			Mental illness	
	Heart attack			Prostate problem				
	High cholesterol			Migraine headaches				

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HOSPITALIZATIONS

Please list the last three times, if any, that you have been hospitalized. Don't include normal pregnancies.

Year	Operation or illness	Hospital and city

SYSTEM REVIEW

Please (✓) the box for each item that you have now or have had in the past and fill in the blank spaces.

GENERAL:
- ☐ weakness
- ☐ fatigue
- ☐ chills
- ☐ night sweats
- ☐ change in weight, appetite or sleeping habits

SKIN:
- ☐ itching
- ☐ rash
- ☐ change in color
- ☐ easy bruising

NERVOUS SYSTEM:
- ☐ headache
- ☐ dizziness
- ☐ double vision
- ☐ muscle weakness
- ☐ numbness
- ☐ loss of coordination

LUNGS:
- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ spitting up blood
- ☐ positive TB test
- ☐ last chest x-ray date:________

HEART:
- ☐ chest pain
- ☐ palpitation (heart pounding)
- ☐ trouble breathing at night
- ☐ trouble climbing stairs
- ☐ easy fatigue
- ☐ ankle swelling

URINARY:
- ☐ pain on urination
- ☐ blood in urine
- ☐ frequent urination
- ☐ previous infections
- ☐ kidney stones

GASTROINTESTINAL:
- ☐ stomach pain/abdominal pain
- ☐ indigestion/heart burn
- ☐ ulcers
- ☐ difficulty swallowing
- ☐ vomiting
- ☐ changes in bowel habits
- ☐ blood in stools
- ☐ hemorrhoids

EYES:
- ☐ glasses/contacts
- ☐ eye pain
- ☐ excessive tearing
- ☐ last eye exam date: ________

EARS:
- ☐ loss of hearing
- ☐ ringing
- ☐ drainage

NOSE/THROAT/SINUSES:
- ☐ nosebleed
- ☐ sore throat
- ☐ hoarseness
- ☐ post nasal drip
- ☐ swelling

MOUTH:
- ☐ dentures
- ☐ bleeding gums
- ☐ toothache, last dental exam: ________

JOINTS & BACK:
- ☐ pain
- ☐ swelling
- ☐ stiffness
- ☐ deformity

MUSCLES:
- ☐ pain
- ☐ weakness
- ☐ twitching

ENDOCRINE:
- ☐ excessively hot
- ☐ excessively cold
- ☐ always thirsty
- ☐ always hungry

PSYCHOLOGICAL:
- ☐ nervousness
- ☐ depression
- ☐ unable to sleep
- ☐ nightmares
- ☐ memory loss

IMMUNIZATIONS:
- ☐ Polio vaccine date: ________
- ☐ Tetanus date: ________

MALE
- ☐ hernia
- ☐ discharge from penis
- ☐ pain in testicles
- ☐ VD
- ☐ sexual difficulties
- ☐ discharge from nipple
- ☐ methods of contraception ________

FEMALE:
- ☐ vaginal itching or burning
- ☐ vaginal discharge
- ☐ problem with menstrual periods
- ☐ last menstrual period date: ________
- ☐ last pap smear date: ________
- ☐ methods of contraception: ________
- ☐ VD
- ☐ sexual difficulties
- ☐ pregnancy, number: ________
- ☐ miscarriages or abortions, number: ______
- ☐ problems during pregnancy
- ☐ lumps in breast
- ☐ discharge from nipple
- ☐ methods of contraception

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SOCIAL PERSONAL HISTORY

You currently live: ☐ alone ☐ with friends ☐ with family

You are: ☐ married ☐ separated ☐ divorced ☐ widowed ☐ never married

Type of work you do: ______ Last grade completed in school: ______

Have you ever been rejected for health reasons by the military, an employer, or an insurance company? ______
If yes, explain: ______

Were you sick, but failed to get medical care in the last year? ______

Did you miss more than ten days of your usual activity last year due to illness? ______

Smoking History: 1. Do you currently smoke? ______ 2. How much per day? ______
3. How many years? ______ 4. Are you a former smoker? ______

Consumption of alcoholic beverages: yes ______ no ______ Amount ______

Do you use marijuana (grass, pot): yes ______ no ______

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:			
RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

HAVE ANY BLOOD RELATIVES HAD ANY OF THE FOLLOWING ILLNESSES?

IF SO, INDICATE RELATIONSHIP (MOTHER, BROTHER, ETC.)

ILLNESS	FAMILY MEMBER
Diabetes	
Cancer	
Blood disease	
Glaucoma	
Epilepsy	
Rheumatoid arthritis	
Tuberculosis	
Gout	
High blood pressure	
Heart disease	

OTHER COMMENTS NOT COVERED ABOVE

______

______

______

Patient Signature ______ Physician Signature ______ Date / /

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