

ADULT PATIENT'S CHECK LIST FOR MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: / / DATE: _____

CURRENT MEDICAL PROBLEMS OR CARE

If you are currently experiencing any illness or medical problem, or if you are being treated by another physician or mental health practitioner, please describe the problem(s) and, if applicable, the name of the physician, health practitioner or medical facility treating you.

Illness or Medical Problem	Treatment	Physician / Medical Facility / Health Practitioner	City

CURRENT MEDICATIONS:

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements) List name, dosage and times per day.

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES:

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

PAST SURGERIES: None — or, list here any past surgeries with approximate age at which performed.

OTHER HOSPITALIZATIONS: List reason and date(s).

ACCIDENTS: No injuries of consequence — or, list any serious type injuries, with approximate age.

PAST MEDICAL ILLNESSES: No serious past illnesses — or, list any serious illness(es), with approximate age.

List any major childhood diseases:

Sexually Transmitted Diseases (past or current): Gonorrhea HIV/AIDS Herpes Chlamydia Syphilis Other

Any blood transfusions: Yes No

FAMILY HISTORY: If any of the following have run in your family, check appropriate block:

Allergies Cancer Tuberculosis Diabetes Heart Disease Strokes Hypertension

Any deaths below age of 55? Who: _____

RECENT TRAVEL AND IMMUNIZATIONS:

Have you traveled out of the country in the last 2 years? ... No Yes, traveled in _____

Write in the dates for the shots you have had: Measles / Mumps / Rubella (MMR) _____ Polio _____

Tetanus / Diphtheria (dt) _____ Typhoid _____ Flu _____ Pneumococcal/Pneumonia _____

Other _____

Have you had a tuberculin (TB) skin test: No Yes Date _____ Result ? Pos. Neg. BCG _____

Living Will/Durable Power of Attorney: Yes No

REVIEW OF SYSTEMS: Place a check mark in the appropriate blocks in the following list of current (within past 3 months) symptoms:

1. HEAD AND NECK		YES	NO			YES	NO			YES	NO
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Severe hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble or hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ears	<input type="checkbox"/>	<input type="checkbox"/>	Chronic nose obstruction	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Failing vision	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from ear(s).....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent sore gums	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Repeated nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged hoarseness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in neck	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. HEART AND LUNGS											
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Smoking history	<input type="checkbox"/>	<input type="checkbox"/>			
Chest pain on effort.....	<input type="checkbox"/>	<input type="checkbox"/>	Have chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>	Past <input type="checkbox"/> Present <input type="checkbox"/>					
Skipping/irregular heart beats	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing/Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ Qty _____					
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Sit up to breathe easier.....	<input type="checkbox"/>	<input type="checkbox"/>	If currently smoking are you interested in quitting?	<input type="checkbox"/>	<input type="checkbox"/>			

2. HEART AND LUNGS (cont.)

	YES	NO		YES	NO		YES	NO
Cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>	Cough or spit up blood.....	<input type="checkbox"/>	<input type="checkbox"/>
Lab test date _____			Frequent chest colds	<input type="checkbox"/>	<input type="checkbox"/>			
Results _____			Have night sweats	<input type="checkbox"/>	<input type="checkbox"/>			

3. STOMACH AND INTESTINES

Chronic abdominal pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Any chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Sigmoidoscopy.....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent nausea	<input type="checkbox"/>	<input type="checkbox"/>	Any black tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	Date _____		
Heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	Any blood from rectum	<input type="checkbox"/>	<input type="checkbox"/>	Results _____		
Appetite loss	<input type="checkbox"/>	<input type="checkbox"/>	Clay colored stools	<input type="checkbox"/>	<input type="checkbox"/>			
Vomit blood	<input type="checkbox"/>	<input type="checkbox"/>	Habitual constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Skin turns yellow.....	<input type="checkbox"/>	<input type="checkbox"/>	Have hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>			

4. URINARY TRACT

Frequent urination.....	<input type="checkbox"/>	<input type="checkbox"/>	Hard to start urinary flow.....	<input type="checkbox"/>	<input type="checkbox"/>	Weak stream/scanty urination	<input type="checkbox"/>	<input type="checkbox"/>
Any blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent night urination	<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Any leakage of urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Passed any stones	<input type="checkbox"/>	<input type="checkbox"/>	Any bedwetting.....	<input type="checkbox"/>	<input type="checkbox"/>
Any retention of urine	<input type="checkbox"/>	<input type="checkbox"/>						

5. OB GYN (For Women Only)

Last menstrual period _____		Previous pap smear	<input type="checkbox"/>	<input type="checkbox"/>	Any breast lumps	<input type="checkbox"/>	<input type="checkbox"/>
If currently having periods do you have:		Date of most recent pap _____			Mammography	<input type="checkbox"/>	<input type="checkbox"/>
Painful menstruation.....	<input type="checkbox"/>	Results _____			Date _____		
Excess menstruation	<input type="checkbox"/>	Current birth control	<input type="checkbox"/>	<input type="checkbox"/>	Results _____		
Bleed between periods.....	<input type="checkbox"/>	Type: _____					
Any missed periods.....	<input type="checkbox"/>	Number of pregnancies _____					
Any vaginal discharge	<input type="checkbox"/>	Number of living children _____					

6. MUSCLES AND JOINTS

Physically handicapped/limited....	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Red or swollen joints.....	<input type="checkbox"/>	<input type="checkbox"/>
Joint or muscle problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Limitation of motion.....	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins.....	<input type="checkbox"/>	<input type="checkbox"/>						

7. NEUROLOGICAL

Numbness.....	<input type="checkbox"/>	<input type="checkbox"/>	Any dizzy spells.....	<input type="checkbox"/>	<input type="checkbox"/>	Any shaking/tremors	<input type="checkbox"/>	<input type="checkbox"/>
Disturbance in walking.....	<input type="checkbox"/>	<input type="checkbox"/>	Any paralysis/weakness	<input type="checkbox"/>	<input type="checkbox"/>	Any falls.....	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with balance or coordination.....	<input type="checkbox"/>	<input type="checkbox"/>	Any strokes.....	<input type="checkbox"/>	<input type="checkbox"/>	Speech disturbance	<input type="checkbox"/>	<input type="checkbox"/>
			Any seizures	<input type="checkbox"/>	<input type="checkbox"/>	Any memory loss	<input type="checkbox"/>	<input type="checkbox"/>

8. PSYCHOLOGICAL

Psychological/emotional / stress problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive fears	<input type="checkbox"/>	<input type="checkbox"/>	History of:		
Psychotherapy/counseling	<input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>
Currently.....	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	Total drinks consumed over past week _____		
In past.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Drug problems	<input type="checkbox"/>	<input type="checkbox"/>
			Serious marital problems	<input type="checkbox"/>	<input type="checkbox"/>	Any mood changes.....	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL HEALTH.....Good Fair Poor

Do you eat a balanced diet? Yes No Explain _____

Do you have a lot of stress? Yes No Explain _____

Do you get regular exercise? Yes No Explain _____

Any exposure to environmental hazards such as chemicals, dust or fumes? Yes No

If yes, please explain:

IF THERE ARE ANY ADDITIONAL HEALTH FACTORS IN YOUR HISTORY
OR IF ANY OF THE ABOVE POINTS NEED CLARIFYING, USE THIS SPACE FOR ADDITIONAL COMMENTS.