The Downtown MedCenter

MEDICAL HISTORY & HEALTH QUESTIONNAIRE

Please use back of form for additional space if needed

Name:	Date:
Reason for visit:	

SOCIAL HISTORY

Marital Status: □ Married □ Divorced □ Single □ Widowed Birthplace:

Current Occupation/Profession: Present Employment:

Military Service: □ No □ Yes → Branch: Dates of Service:

CHILDREN

AGE	SEX	STATE OF HEALTH	AGE	SEX	STATE OF HEALTH

CURRENT ILLNESSES OR CONDITIONS	MEDICATIONS	DOSAGE

OTHER MEDICATIONS

(All those not listed above - include other prescriptions, herbal supplements, vitamins, and over the counter medicines)

TYPE	REASON - why you take it	AMOUNT/DOSAGE

ALLERGIES - LIST ANY DRUG, FOOD, INSECT OR OTHER ALLERGY AND EXPLAIN ANY REACTION

NAME/TYPE	REACTION

FOR WOMEN ONLY

Are you currently pregnant □ No □ Yes → How many months:		Date of last menses:	
Last PAP Test: □ NL □ ABNL	Birth Control □ No □ Yes □ Type:		
Number of pregnancies:	Live Births:	Miscarriages:	Abortions:
Complications of pregnancies:			
GYN Surgeries: □ Tubal ligation □ Partial Hysterectomy □ Complete Hysterectomy □ Other:			
Date of last Mammogram: □ NL □ ABNL → Results/Comments:			

VACCINES AND IMMUNIZATIONS (Date and results of recent inoculations)

TETANUS:	T.B. SKIN TEST: □ NEG □ POS	HEPATITIS B: □ Completed series of 3
FLU SHOT:	PNEUMOVAX (pneumonia shot):	OTHER:

HOSPITALIZATIONS AND SURGERIES

YEAR	REASON OR PROBLEM	HOSPITAL OR SURGERY CENTER	PHYSICIAN/SURGEON

HEALTH HABITS

TOBACCO: □ NEVER □ PREVIOUS SMOKER - DATE QUIT: □ CURRENT SMOKER - PACKS A DAY: YEARS:

CHEWING TOBACCO OR SNUFF: □ NEVER □ PREVIOUS - DATE QUIT: □ CURRENT - AMOUNT: YEARS:

CAFFEINE: □ NO □ Coffee □ Tea □ Cola □ Chocolate Drinks per day:

ALCOHOL: □ NO □ Beer □ Wine □ Liquor/Whiskey Drinks per day: Per week:

DIETS: □ NO SPECIAL DIETS □ Low Fat & Cholesterol □ Diabetic □ Low Salt: □ Low Calorie □ Other:

EXERCISE: □ NO REGULAR EXERCISE □ Type of exercises: How Often: □ Daily □ _____ x per week

DRUGS: □ NONE □ Illicit or "Recreational" Drugs → Type: How Often: □ Daily □ _____ x per week

FAMILY HISTORY

FAMILY MEMBER	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS(s)				
SISTER(s)				

PLEASE CHECK ANY COMMON FAMILY ILLNESS OR CONDITION AND NOTE WHO WITH ANY EXPLANATIONS:

□ ARTHRITIS	□ HIGH BLOOD PRESSURE	□ INFECTIOUS DISEASE
□ ALCOHOLISM	□ KIDNEY DISEASE	□ HIV OR AIDS
□ DRUG ADDICTION	□ LIVER DISEASE	□ MENTAL ILLNESS
□ ALLERGIES	□ MIGRAINE HEADACHE	□ HEART DISEASE
□ ASTHMA	□ OSTEOPOROSIS	□ COLON CANCER
□ BLEEDING DISORDER	□ SEIZURES	□ LUNG CANCER
□ DEPRESSION	□ STROKE	□ BREAST CANCER
□ DIABETES	□ TUBERCULOSIS	□ SKIN CANCER
□ GLAUCOMA	□ THYROID DISEASE	□ OTHER

EXPLANATIONS:

HEALTH MAINTENANCE

LABS/TESTS or EXAMS	DATE	RESULT	COMMENTS/NOTES
CHOLESTEROL			
PSA - ♂			
RECTAL - STOOL for BLOOD			
COLONOSCOPY			
CHEST X-RAY			
EKG			
LAST EYE EXAM			
LAST DENTAL EXAM			

OTHER DIAGNOSTIC LABS/TEST: TYPE: WHEN: WHERE:

REVIEW OF SYSTEMS - PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED AND EXPLAIN

GENERAL
- □ Fever
- □ Chills
- □ Weight gain
- □ Weight loss
- □ Fatigue
- □ Frequent infections

SKIN
- □ Rashes
- □ Change in moles
- □ Sores
- □ Nail disorders
- □ Itching

BLOOD
- □ Anemia
- □ Easy bruising or bleeding
- □ Blood clots
- □ Blood type: _____
- □ Blood transfusion

HEAD/FACE/NECK
- □ Headache
- □ Neck swelling
- □ Facial pain
- □ Enlarged lymph nodes

EYES
- □ Change in vision
- □ Eyeglasses or contacts
- □ Blurred vision
- □ Double vision
- □ Glaucoma
- □ Cataracts
- □ Sensitivity to light
- □ Eye surgeries

EARS
- □ Hearing loss
- □ Ringing in ears
- □ Ear pain
- □ Dizziness or vertigo
- □ Frequent ear infections
- □ Drainage from ears

NOSE/SINUS
- □ Change in smell
- □ Pain in sinus
- □ Frequent bloody nose
- □ Allergies
- □ Post nasal drip
- □ Sneezing
- □ Frequent sinus infections

MOUTH/THROAT
- □ Change in taste
- □ Change in voice
- □ Sores in mouth
- □ Hoarseness
- □ Bleeding gums
- □ Sore throat
- □ Dentures
- □ Pain in teeth or gums

RESPIRATORY
- □ Chronic cough
- □ Frequent bronchitis
- □ Recent pneumonia
- □ History of T.B.
- □ Asthma
- □ Emphysema
- □ Lung cancer

CARDIAC
- □ Chest pain or tightness
- □ Shortness of breath
- □ Angina or chest pain with exercise
- □ Heart attack
- □ Palpitations or fast heart beat
- □ Heart murmur
- □ Swelling in legs or ankles
- □ Heart failure
- □ High blood pressure
- □ Rheumatic fever

GASTROINTESTINAL
- □ Change in appetite
- □ Difficulty swallowing
- □ Nausea or vomiting
- □ Abdominal pain
- □ Vomiting blood
- □ Food intolerance
- □ Bloating
- □ Diarrhea
- □ Constipation
- □ Change in stool color (black stool)
- □ Jaundice
- □ Gall bladder disease
- □ Hepatitis
- □ Ulcers or indigestion
- □ Colitis
- □ Crohn's disease
- □ Diverticulitis
- □ Hernia
- □ Hemorrhoids or rectal fissures
- □ Polyps or colon cancer

MUSCULOSKELETAL
- □ Joint pain
- □ Joint redness or swelling
- □ Stiffness of muscles or joints
- □ Weakness
- □ Muscle cramps or spasm
- □ Arthritis
- □ Fractures or broken bones
- □ Gout
- □ Back pain

ENDOCRINE
- □ Thyroid enlargement
- □ Diabetes
- □ Excessive thirst or urination
- □ Weight changes
- □ Increased sweating
- □ Change in hair or skin

NEUROLOGIC
- □ Stroke
- □ TIA
- □ Blackouts
- □ Seizures
- □ Paralysis
- □ Memory loss
- □ Confusion
- □ Weakness
- □ Head injury
- □ Numbness or tingling
- □ Facial droop
- □ Speech problems
- □ Polio
- □ Meningitis

GENITOURINARY
- □ Frequency of urination
- □ Painful urination
- □ Blood in urine
- □ Wake up at night to urinate
- □ Flank pain
- □ Kidney stones
- □ Urinary tract or bladder infections
- □ Sexually transmitted disease
- □ Aids/HIV
- □ Herpes

MEN
- □ Dribbling
- □ Loss of force of stream
- □ Discharge from penis
- □ Mass or pain in testicles
- □ Change in libido or sexual desire
- □ Erectile dysfunction

BREAST
- □ Breast lumps
- □ Nipple discharge or bleeding
- □ Rash around nipple
- □ Breast cancer

GYNECOLOGIC
- □ Vaginal Dryness
- □ Mood swings
- □ Hot flashes
- □ Hormone replacement therapy
- □ Pain with intercourse
- □ Change in libido

PSYCHIATRIC
- □ Mood swings
- □ Depression
- □ Hyperactivity
- □ Insomnia
- □ Stress or anxiety
- □ Suicidal thoughts
- □ Intent to hurt yourself
- □ Anorexia
- □ Bulimia
- □ Mental illness
- □ Drug or alcohol abuse

EXPLANATIONS (please use back for additional room)