PERSONAL MEDICAL HISTORY

Check all SYMPTOMS that apply currently

GENERAL	GASTROINTESTINAL	EYE/EAR/NOSE/THROAT	WOMEN ONLY
❍ Anxiety	❍ Appetite poor	❍ Bleeding gums	❍ Abnormal vaginal bleeding
❍ Depression	❍ Bloating	❍ Difficulty swallowing	❍ Breast lump or pain
❍ Dizziness/Fainting	❍ Bowel changes	❍ Hoarseness	❍ Breast discharge
❍ Fever	❍ Constipation	❍ Persistent cough	❍ Extreme menstrual pain
❍ Forgetfulness	❍ Diarrhea	❍ Earache/Ear discharge	❍ Hot flashes
❍ Loss of sleep	❍ Excessive thirst	❍ Ringing in ears	❍ Painful intercourse
❍ Loss of weight	❍ Gas	❍ Loss of hearing	❍ Vaginal discharge
❍ Numbness	❍ Hemorrhoids	❍ Sinus problems	❍ Menstrual flow irregular
❍ Sweats	❍ Indigestion	❍ Nosebleeds	❍ Miscarriages # _____
GENITOURINARY	❍ Mouth sores	❍ Hay fever	Last Pap Smear_____
❍ Blood in urine	❍ Nausea	❍ Blurred vision	❍ Normal ❍ Abnormal
❍ Frequent urination	❍ Rectal bleeding	❍ Crossed eyes	First day of last menstrual period _____
❍ Painful urination	❍ Stomach pain	❍ Double vision	Last mammo/thermogram _____
❍ Cloudy urine	❍ Vomiting	❍ Vision – flashes/halos…	❍ Normal ❍ Abnormal
❍ Lack of bladder control	❍ Vomiting blood		

MUSCLE/JOINT/BONE Pain, weakness or numbness in:		CARDIOVASCULAR	SKIN	MEN ONLY
❍ Head	❍ Buttocks	❍ Chest pain	❍ Blisters or pustules	❍ Erection difficulties
❍ Eyes	❍ Shoulders	❍ High/Low blood pressure	❍ Bruise easily	❍ Difficulty urinating
❍ Ears	❍ Arms	❍ Irregular/Rapid heart rate	❍ Hives	❍ Lump on testicles
❍ Neck	❍ Wrist	❍ Poor circulation	❍ Itching/Rash	❍ Penis discharge
❍ Chest	❍ Hands	❍ Shortness of breath	❍ Change in moles	❍ Sore on penis
❍ Abdomen	❍ Hips	❍ Swelling of ankles	❍ Scars	❍ Other:
❍ Genitals	❍ Legs	❍ Varicose veins	❍ Sores that will not heal	
❍ Back	❍ Feet	❍ Other:	❍ Other:	

Check all CONDITIONS that apply currently or in the past

❍ AIDS	❍ Cataracts	❍ Heart disease	❍ Measles	❍ Prostate problems
❍ Appendicitis	❍ Chemical dependency	❍ Hepatitis	❍ Migraines	❍ Rheumatic fever
❍ Arthritis	❍ Chicken pox	❍ Herpes	❍ Multiple sclerosis	❍ Scarlet fever
❍ Asthma	❍ Diabetes	❍ High cholesterol	❍ Mumps	❍ Stroke
❍ Bleeding disorder	❍ Emphysema	❍ HIV positive	❍ Pacemaker	❍ Thyroid problems
❍ Breast lump	❍ Epilepsy	❍ Kidney disease	❍ Pneumonia	❍ Tuberculosis
❍ Cancer	❍ Glaucoma	❍ Liver disease	❍ Polio	❍ Ulcers

Additional Comments:

SOCIAL HISTORY *please check those that apply*

❍ Single ❍ Married ❍ Divorced ❍ Significant other ❍ Adopted

FAMILY MEDICAL HISTORY *please check those that apply*

If immediate family has had any of the following – please indicate the # and relative			#	Relative(s)
1. Alcoholism	7. Cancer (specify)	13. Heart Disease		
2. Alzheimer's	8. Cholesterol high	14. High blood pressure		
3. Anemia	9. Diabetes	15. Mental Illness		
4. Arthritis	10. Epilepsy	16. Migraine		
5. Asthma	11. Glaucoma	17. Osteoporosis		
6. Bleeds easily	12. Hay fever	18. Thyroid		
Other:				

Relation	Alive	Present health or cause of death:
Father	❍ Y ❍ N	
Mother	❍ Y ❍ N	
Spouse	❍ Y ❍ N	

Relation	# Living	Present health:	# Deceased	Cause of death:
Brothers	#			
Sisters	#			
Children	#			