PATIENT MEDICAL HISTORY

NAME:_____BIRTHDATE:_____AGE:_____

FAMILY PHYSICIAN:_____

OTHER DOCTORS YOU SEE:_____

_____

Describe what medical problems you are having:

List medications and dosages:

List any allergies:

Other medical problems you may have:

List dates and reasons for any hospitalizations, surgeries or injuries:

This is a two sided form

NAME:_____DATE:_____

FAMILY MEDICAL HISTORY

Has any of the following family members died as a result of or currently have a hereditary disease such as: Colorectal Cancer, Heart Disease, Diabetes, etc. IF YES, please list below:

FATHER _____
MOTHER _____
SIBLINGS _____
CHILDREN _____

Has anyone in your family had Colon Cancer? YES NO Who?_____

SOCIAL HISTORY

Do you smoke? YES NO How much?_____
Do you drink alcohol? YES NO How much?_____

REVIEW OF SYMPTOMS

General

( )Anemia
( )Bruise Easily/Bleed Too Long
( )Diabetes
( )Chronic Fatigue
( )Cancer What Kind?_____
( )Weight Loss Amount/Since When_____
( )Transfusion
( )Thyroid Disease
( )Fever

Ears, Nose, Throat

( )Ringing In Ears
( )Glaucoma
( )Dizzy Spells
( )Sinus
( )Poor Vision
( )Hoarseness

Lungs

( )Emphysema/COPD
( )Asthma
( )Short of Breath
( )Sleep Apnea
( )Chronic Bronchitis
( )Chronic Cough
( )Coughing up Blood

Heart

( )Chest Pain
( )High Blood Pressure
( )Irregular Heart Beat
( )Phlebitis
( )Palpitations
( )Ankle Swelling
( )Heart Murmur
( )Heart Valve Problems

Neurologic/Psychiatric

( )Numbness Or Tingling
( )Frequent Headaches
( )Tremor
( )Depression
( )Nervousness/Anxiety
( )Stroke
( )Migraines
( )Seizure
( )Memory Loss
( )Panic Attacks

Gastrointestinal

( )Diarrhea
( )Heartburn
( )Abdominal Pain
( )Blood in Stool
( )Liver Disease
( )Trouble Swallowing
( )Polyps
( )Diverticulitis
( )Constipation
( )Nausea
( )Vomiting
( )Bloating
( )Gas

Urinary/Reproductive

( )Urine Infections
( )Blood In Urine
( )Decreased Flow Or Force
( )Urination at Night
( )Endometriosis

( )Date Of Last Menstrual Cycle
( ) # of Pregnancies_____
( ) # of Live Births_____

Bones & Joints

( )Arthritis
( )Osteoporosis

Skin (Allergic/Immunologic)

( )Rash ( )Hives
( )Allergic Reactions
Type(s)_____
_____

Other Problems_____

_____
_____
_____
_____

_____

Signature of Patient **Date**

This is a two sided form