## MEDICAL HISTORY (update every 6 months)

**Patient Name :** _____ **Date:** _____

**Women **Please notify the nurse IF you are or think you might be pregnant. **Height:** _____ **Weight:** _____

**PAST SURGICAL HISTORY:**

_____

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| **PAST MEDICAL HISTORY:** | | | | | | **List any other Medical History Here:** |
|---|---|---|---|---|---|---|
| High Blood Pressure | YES | NO | COPD | YES | NO | |
| Seizures | YES | NO | Heart Attack | YES | NO | |
| Diabetes | YES | NO | Strokes | YES | NO | |
| Yellow Jaundice | YES | NO | Bleeding Difficulties | YES | NO | |
| Anesthetic Difficulties | YES | NO | Heart Disease | YES | NO | |
| Colon Cancer | YES | NO | Breast Cancer | YES | NO | |

**FAMILY HISORTY:**

| | | | |
|---|---|---|---|
| Mother | Alive | Deceased | Mother's Medical History: |
| Father | Alive | Deceased | Father's Medical History: |

**SOCIAL HISTORY:**

| | | |
|---|---|---|
| Do you use tobacco products? | 1 Former Smoker? | Amount? |
| Do you drink Alcohol? | | Amount? |
| Occupation? | | Level of Education? |
| Who lives at home: | | |

**SYSTEMS REVIEW:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fever | YES | NO | Dizziness | YES | NO | Irregular Periods (female) | YES | NO |
| Chills | YES | NO | Nausea | YES | NO | Breast Lumps | YES | NO |
| Weight Loss | YES | NO | Vomiting | YES | NO | Testicular Mass/Pain (male) | YES | NO |
| Tiredness | YES | NO | Constipation | YES | NO | Prostate Problems (male) | YES | NO |
| Double Vision | YES | NO | Diarrhea | YES | NO | Blood in Urine | YES | NO |
| Blurred Vision | YES | NO | Hemorrhoids | YES | NO | Frequent Urination | YES | NO |
| Hard of Hearing | YES | NO | Rectal Pain | YES | NO | Difficulty Urinating | YES | NO |
| Asthma | YES | NO | Rectal Bleeding | YES | NO | Dribbling Urine | YES | NO |
| Shortness of Breath | YES | NO | Pain Before/After eating | YES | NO | Other: (please list below) | | |
| Cough | YES | NO | Trouble swallowing | YES | NO | | | |
| Blood in Cough | YES | NO | Stomach Pain | YES | NO | | | |
| Chest Pain | YES | NO | Hernias | YES | NO | | | |
| Swelling | YES | NO | Breast Pain | YES | NO | | | |
| Irregular Heartbeat | YES | NO | Nipple Discharge | YES | NO | | | |

**MEDICATIONS:**

| | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

**ALLERGIES:**

_____

_____

**Are you on Dialysis?** Yes No **Days for Dialysis ( please circle)** Mon Tue Wed Thur Fri Sat

## MEDICAL HISTORY (update every 6 months)

**Patient Name :** _____ **Date:** _____

****Women **Please notify the nurse if you are or think you might be pregnant. Height:** _____ **Weight:** _____

**PAST SURGICAL HISTORY:**

_____

_____

_____

| **PAST MEDICAL HISTORY:** | | | | | | **List any other Medical History Here:** |
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| High Blood Pressure | YES | NO | COPD | YES | NO | |
| Seizures | YES | NO | Heart Attack | YES | NO | |
| Diabetes | YES | NO | Strokes | YES | NO | |
| Yellow Jaundice | YES | NO | Bleeding Difficulties | YES | NO | |
| Anesthetic Difficulties | YES | NO | Heart Disease | YES | NO | |
| Colon Cancer | YES | NO | Breast Cancer | YES | NO | |

| **FAMILY HISORTY:** | | | |
|---|---|---|---|
| Mother | Alive | Deceased | Mother's medical history: |
| Father | Alive | Deceased | Father's medical history: |

| **SOCIAL HISTORY:** | | |
|---|---|---|
| Do you use tobacco products? | Former Smoker? | Amount? |
| Do you drink Alcohol? | | Amount? |
| Occupation? | | Level of Education? |
| Who lives at home: | | |

| **SYSTEMS REVIEW:** | | | | | | |
|---|---|---|---|---|---|---|
| Weight Loss | YES | NO | Diarrhea | YES | NO | Other: (please list below) |
| Hair Loss | YES | NO | Blood in Urine | YES | NO | |
| Double Vision | YES | NO | Painful Urination | YES | NO | |
| Blurred Vision | YES | NO | Open Wounds | YES | NO | |
| Drainage | YES | NO | Headaches | YES | NO | |
| Hard of Hearing | YES | NO | Seizures | YES | NO | |
| Cough | YES | NO | Depression | YES | NO | |
| Blood in Cough | YES | NO | Anxiety | YES | NO | |
| Wheezing | YES | NO | Excess Cold | YES | NO | |
| Heart Palpitations | YES | NO | Excess Thirst | YES | NO | |
| Murmur | YES | NO | Bleed Easily | YES | NO | |
| Nausea | YES | NO | Bruise Easily | YES | NO | |
| Vomiting | YES | NO | | YES | NO | |
| Constipation | YES | NO | | YES | NO | |

| **MEDICATIONS:** | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

**ALLERGIES:**

_____

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**Are you on Dialysis?** Yes No **Days for Dialysis ( please circle)** Mon Tue Wed Thur Fri Sat