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	☐	☐	Severe hearing loss	☐	☐	Frequent colds	☐	☐
Dizzy spells	☐	☐	Ringing in ears	☐	☐	Sinus trouble or hay fever	☐	☐
Wear glasses	☐	☐	Pain in ears	☐	☐	Chronic nose obstruction	☐	☐
Failing vision	☐	☐	Discharge from ear(s)	☐	☐	Persistent sore gums	☐	☐
Eye pain	☐	☐	Repeated nosebleeds	☐	☐	Prolonged hoarseness	☐	☐
Double vision	☐	☐	Teeth problems	☐	☐	Swelling in neck	☐	☐
2. HEART AND LUNGS								
Heart problems	☐	☐	Swelling of ankles	☐	☐	Smoking history	☐	☐
Chest pain on effort	☐	☐	Have chronic cough	☐	☐	Past ☐ Present ☐		
Skipping/irregular heart beats	☐	☐	Difficulty breathing/Shortness of Breath	☐	☐	Type _____ Qty _____		
Hypertension	☐	☐	Sit up to breathe easier	☐	☐	If currently smoking are you interested in quitting?	☐	☐

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2. HEART AND LUNGS (cont.)

	YES	NO		YES	NO		YES	NO
Cholesterol	☐	☐	Wheezing	☐	☐	Cough or spit up blood	☐	☐
Lab test date _____			Frequent chest colds	☐	☐			
Results _____			Have night sweats	☐	☐			

3. STOMACH AND INTESTINES

Chronic abdominal pain	☐	☐	Any chronic diarrhea	☐	☐	Sigmoidoscopy	☐	☐
Persistent nausea	☐	☐	Any black tarry stools	☐	☐	Date _____		
Heartburn	☐	☐	Any blood from rectum	☐	☐	Results _____		
Appetite loss	☐	☐	Clay colored stools	☐	☐	_____		
Vomit blood	☐	☐	Habitual constipation	☐	☐			
Skin turns yellow	☐	☐	Have hemorrhoids	☐	☐			

4. URINARY TRACT

Frequent urination	☐	☐	Hard to start urinary flow	☐	☐	Weak stream/scanty urination	☐	☐
Any blood in urine	☐	☐	Frequent night urination	☐	☐	Pain with urination	☐	☐
Any leakage of urine	☐	☐	Passed any stones	☐	☐	Any bedwetting	☐	☐
Any retention of urine	☐	☐						

5. OB GYN (For Women Only)

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

6. MUSCLES AND JOINTS

Physically handicapped/limited	☐	☐	Shoulder pain	☐	☐	Red or swollen joints	☐	☐
Joint or muscle problems	☐	☐	Back pain	☐	☐	Limitation of motion	☐	☐
Varicose veins	☐	☐						

7. NEUROLOGICAL

Numbness	☐	☐	Any dizzy spells	☐	☐	Any shaking/tremors	☐	☐
Disturbance in walking	☐	☐	Any paralysis/weakness	☐	☐	Any falls	☐	☐
Trouble with balance			Any strokes	☐	☐	Speech disturbance	☐	☐
or coordination	☐	☐	Any seizures	☐	☐	Any memory loss	☐	☐

8. PSYCHOLOGICAL

Psychological/emotional /			Excessive fears	☐	☐	History of:		
stress problems	☐	☐	Nervous breakdown	☐	☐	Alcohol problems	☐	☐
Psychotherapy/counseling	☐	☐	Depression	☐	☐	Total drinks consumed		
Currently	☐	☐	Sexual problems	☐	☐	over past week _____		
In past	☐	☐	Serious marital problems	☐	☐	Drug problems	☐	☐
						Any mood changes	☐	☐

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.