Medical History

Name: _____ DOB: _____ Date: _____

Reason for today's visit:

Past Medical History
(please check all that apply)

- Blood Disorders ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Lung Disease ☐
- Diabetes ☐
- Peptic Ulcer Disease ☐
- Cancer ☐
- Liver Disease ☐
- Psychiatric Disorder ☐
- Other (please list below) ☐

Prior hospital Admissions:

	Dates

Previous Surgial History:

	Dates

Past Blood Transfusions:

	Dates

Social History:

Marital Status:	☐ Married	☐ Divorced	☐ Single
Tobacco Use:	☐ Yes	☐ No	How Much? _____
Alcohol Use:	☐ Yes	☐ No	How Much? _____
Drug Use:	☐ Yes	☐ No	How Much? _____

Occupation: _____

Patient Name:

Family History

Medical issues on your mother's side: _____

_____

_____

_____

Medical Issues on your father's side:_____

_____

_____

_____

Review of Systems (please circle all which are applicable) :

Constitutional: Weight loss Weight gain Fever Chills Sweats Fatigue Weakness

Eyes: Wear glasses Blurry vision Flashes of light Blindness

Ears, Nose, Mouth: Ear ache Poor hearing Sore throat

Cardiovascular: Chest Pain Palpitations Swelling of feet

Respiratory: Shortness of breath Cough Asthma

Gastrointestinal: Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool

Genitourinary: Painful urination Frequent urination Nighttime urination
Problems w/testicles
Abnormal periods Last menstrual period: _____ *DATE*

Musculoskeletal: Muscle pain Joint pain

Skin: Rash Sores on skin Skin cancer Boils

Neurological: Heme/ Headache Dizziness Seizures Numbness Tingling

Lymphatic: Swollen lymph glands Anemia

Do you have other symptoms? (please list) _____

_____

_____

_____

_____

_____

Do you have a Living Will? ☐ Yes ☐ No

If "Yes", what are the contents?

☐ No Resuscitation
☐ No Feeding Tubes
☐ No Medication Support
☐ No Mechanical Ventilation
☐ Unaware of Contents
☐ Other _____

Do you have a Durable Power of Attorney? ☐ Yes ☐ No **Name:** _____