# Past Medical History Form

**Family History Key**

M- Mother F- Father
MGM- maternal grand mother
MGF- maternal grandfather
PGM-paternal grandmother
PGF- paternal grandfather
MA- maternal aunt B- Brother
PA- paternal aunt SIS- Sister
MU-maternal uncle SON-son
PU- paternal uncle DA- daughter

Name of Patient: _____

Date of Birth: _____

## Male

**Have you ever had or have:** **Personal History** **Family History**

| X | Disease | Date of Diagnosis/ Explanation | Which family member - use key |
|---|---|---|---|
| | **High blood pressure** | | |
| | **High cholesterol** | | |
| | **Abnormal heart rhythm** | | |
| | **Heart murmur** | | |
| | **Peripheral arterial disease** | | |
| | **Congestive heart failure** | | |
| | **Heart attack** | | |
| | **Other problem with heart or arteries/veins** | | |
| | **Asthma** | | |
| | **Allergies** | | |
| | **Blood clot in lung** | | |
| | **Pulmonary high blood pressure** | | |
| | **Sleep apnea (stop breathing when asleep)** | | |
| | **Excessive snoring** | | |
| | **Chronic sinus issues** | | |
| | **COPD** | | |
| | **Emphysema** | | |
| | **Other lung problems** | | |
| | **Stomach ulcer** | | |
| | **Chronic heartburn** | | |
| | **Irritable bowel syndrome** | | |
| | **Crohn's disease** | | |
| | **Ulcerative colitis** | | |
| | **Chronic constipation** | | |
| | **Hemorrhoids** | | |
| | **Pancreatitis** | | |
| | **Liver disease/ Hepatitis** | | |
| | **Gallstones** | | |
| | **Diverticulitis** | | |
| | **Other problems with your digestive tract** | | |
| | **Hypothyroidism** | | |
| | **Hyperthyroidism** | | |
| | **Diabetes** | | |
| | **Osteopenia/ Osteoporosis** | | |
| | **Other endocrine issues** | | |

Name of Patient: _____ Date of Birth: _____

**Have you ever had or have:** **Personal History** **Family History**

| X | Disease | Date of Diagnosis/ Explanation | Which family member |
|---|---|---|---|
| | **Warts** | | |
| | **Eczema** | | |
| | **Psoriasis** | | |
| | **Abnormal moles** | | |
| | **Seizures** | | |
| | **Migraines** | | |
| | **Chronic headaches** | | |
| | **Stroke or TIA** | | |
| | **Dementia** | | |
| | **Other neurological problems** | | |
| | **Urinary leakage** | | |
| | **Endometriosis** | | |
| | **Fertility Problems** | | |
| | **Uterine Fibroids** | | |
| | **Poly cystic ovarian disease** | | |
| | **Sexually transmitted disease** | | |
| | **Irregular periods** | | |
| | **Kidney stones** | | |
| | **Gout** | | |
| | **Arthritis** | | |
| | **Rheumatoid arthritis** | | |
| | **Fractures** | | |
| | **Lupus** | | |
| | **Blood transfusion** | | |
| | **Clotting/ Bleeding issues** | | |
| | **Anemia** | What kind | |
| | **Sickle cell trait/ Disease** | | |
| | **Thalassemia** | | |
| | **Anxiety** | | |
| | **Bipolar Disorder** | | |
| | **Depression** | | |
| | **ADD/ADHD** | | |
| | **Substance abuse/inc. alcohol** | | |
| | **Cancer** | What type/ treatment | |
| | **Other medical issues not listed** | | |

Name of Patient: _____ Date of Birth: _____

## Surgeries

| X | Surgery | Date | X | Surgery | Date |
|---|---|---|---|---|---|
| | Tonsillectomy | | | Hysterectomy | |
| | Tubes in ears | | | Tubal ligation | |
| | Appendectomy | | | Cataract R/L | |
| | Gallbladder removal | | | Cosmetic | |
| | Back Surgery | | | Heart Surgery | |
| | Joint Surgery | | | Hernia | |
| | Joint replacement | | | C-section | |
| | Other | | | Other | |

## Procedures

**Have you ever had:**

| X | Procedure | Date | X | Procedure | Date |
|---|---|---|---|---|---|
| | Heart catheterization | | | Echocardiogram | |
| | Colonoscopy | | | Bone Density Scan | |
| | Upper scope (EGD) | | | Prostate Check or PSA | |

## Social

| | |
|---|---|
| Occupation: | |
| Highest level of education: | |
| Marital Status: | Single Partner (girlfriend/boyfriend) Engaged Married Divorced Widowed |
| Sexual Orientation | Women Men Both |
| Number of children: | Biological: Stepchildren: Adopted: |
| Last tetanus shot: | |
| Do you live by yourself or with others? | |
| Exercise level? | None 1-2/week 3-4/week 5-7/week |
| How many alcoholic drinks per week? | Never Rare 0-3 4-6 7-10 11-14 >14 |
| Have you ever had a problem with alcohol use? | Yes No |
| Diet | Regular Vegetarian Vegan Gluten-free Other |
| General Stress Level | Low Medium High |
| Have you ever smoked? Current? | How much? How long? |
| Past? | How much? How long? |
| Smokeless tobacco? Cur/Past? | How much/ How long? |
| Regular use of marijuana? | |
| Other illicit drugs? Past/Present? | Any problems with controlled substances? Like prescription medications? |
| Any problems with drug use? | Yes No |
| Do you drink caffeine? How much per day? | Soda? (Diet) # (Sugar)# Coffee # Tea# Energy Drinks# |

Name of Patient: _____ Date of Birth: _____

## Safety

| | |
|---|---|
| **Do you use seatbelts regularly?** | |
| **Do you use sunscreen regularly?** | |
| **Do you have guns present in the home?** | **If so are they locked away from children?** |
| **Do you have a smoke alarm at home?** | |
| **Do you wear a bike helmet?** | |
| **Any history of domestic violence?** | |
| **Any history of sexual violence?** | |

## Personal

| |
|---|
| **Do you have any pets?** |
| **What do you like to do for fun or pass time?** |
| **Other things that you would like to share about yourself?** |

## Medication Allergies/Food Allergies/Contact Allergies

| Medication/Food/Contact | Reaction |
|---|---|
| | |
| | |
| | |
| | |

## Current Medications

***Please list reason for taking each medication***

**1.** _____ **5.** _____

**2.** _____ **6.** _____

**3.** _____ **7.** _____

**4.** _____ **8.** _____

Name of Patient: _____ Date of Birth: _____

## Vitamins/ Supplements

**1.** _____ **3.** _____

**2.** _____ **4.** _____

# Past Medications

| Medication | Reason for taking | Medication | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Health Goals

**Please list health goals that you would like to reach for yourself**

| |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |

# Male Review of Systems

## Please circle recent symptoms and use lines below to explain. List #.

1. **Constitutional:** fatigue, poorly (malaise), fever, night sweats, weight gain or loss that doesn't make sense
2. **Eyes:** dry eyes, irritation, vision change, discharge from eyes, foreign body sensation in eyes
3. **Ears:** ear pain, ear congestion, ears popping, discharge from the ears, difficulty hearing
4. **Nose:** nasal congestion, nasal discharge, post-nasal drip, maxillary sinus pain, frontal sinus pain
5. **Mouth/Throat:** sore throat, snoring, mouth ulcer, teeth abnormalities
6. **Cardiovascular:** chest pain, shortness of breath when lying down, rapid or irregular heartbeat (palpitations), excessive sweating
7. **Respiratory:** cough, wheezing, shortness of breath
8. **Gastrointestinal:** heartburn, nausea, vomiting, diarrhea, constipation, abdominal pain, bloating
9. **Genitourinary:** pain with urination, urine leakage, foul-smelling urine, increased urinary frequency, blood in urine, change in strength of urinary stream, unable to completely empty bladder, erectile dysfunction
10. **Musculoskeletal:** muscle aches, muscle weakness, joint pain, back pain
11. **Skin:** abnormal moles, rash, abnormal skin lesions, breast lump, change in the breast skin
12. **Neurologic:** headaches, dizziness, weakness, numbness
13. **Psych** depression, anxiety, sleep disturbances, mania, feeling unsafe in relationship, alcohol or substance abuse, difficulty falling asleep, early morning waking, not feeling rested after adequate sleep, loss of interest in activities, loss of pleasure from usual activities, inappropriate feelings of guilt, decreased energy, decreased motivation, decreased concentrating ability, abnormal appetite, feeling like hurting self, feeling so badly that you wouldn't mind if you died in your sleep, feeling actively suicidal, feeling emotionally detached, feeling unique and all-powerful (grandeur), disturbing or unusual thoughts, feelings, or sensations, decreased need for sleep, impulsive behavior, pressured speech, causing anger in friends and family
14. **Endocrine:** change in weight distribution, increased hair loss, excessively dry skin, change in color of skin, feelings of weakness and fatigue, feeling more hot or cold than others, hot flashes, abnormal hair growth,
15. **Hematologic/Lymphatic** swollen glands, abnormal bruising
16. **Allergies:** runny nose, sinus pressure, itching, hives, frequent sneezing

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