

## PERSONAL PAST MEDICAL HISTORY

First / Last name	Date of Birth	Today's Date (M/D/Y)
Referred by	Doctor last seen	When
		Why

Allergies to Medications	Reactions

Recent X-rays or Lab Tests	Test	Result	Date

Present Medications			
Drug	For	Drug	For

Surgery/Operations	Reason	Date	Hospital / Doctor

Non-Surgical Hospitalizations	Illness / Injury	Date	Hospital / Doctor

Social History	
Occupation _____	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, pack(s) per day?: _____
Sleep (amount daily) _____	Do you dip? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, daily amount?: _____
Exercise (amount daily) _____	If quit tobacco use, how long ago and how long did you use tobacco? _____
Hobbies _____	
Childhood Diseases _____	Do you use any of the following? If so, describe daily amounts.
Immunizations _____	<input type="checkbox"/> Alcohol _____
Tetanus _____	<input type="checkbox"/> Recreation Drugs _____
	<input type="checkbox"/> Coffee/Tea _____

**Family Medical History**

Living	Age(s)	Health	If deceased, cause of death
Spouse	_____	_____	_____
Children	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____

Check box if all answers are "no"

Have any of your blood relatives ever had any of the following conditions:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Peptic Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever/Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Review of Systems:** Have you ever had: (check yes or no and give date of onset) Check box if all answers are "no"

**Constitutional Symptoms**

Fever  Yes  No

Chills  Yes  No

Other \_\_\_\_\_

**Eyes**

Blurred Vision  Yes  No

Pain  Yes  No

Other \_\_\_\_\_

**Ear/Nose/Throat/Mouth**

Ear Infection  Yes  No

Sore Throat  Yes  No

Other \_\_\_\_\_

**Respiratory**

Wheezing  Yes  No

Frequent Coughing  Yes  No

Other \_\_\_\_\_

**Gastrointestinal**

Abdominal pain  Yes  No

Indigestion/reflux  Yes  No

Other \_\_\_\_\_

**Musculoskeletal**

Joint Pain  Yes  No

Neck Pain  Yes  No

Other \_\_\_\_\_

**Integumentary**

Skin Rash  Yes  No

Persistent Itching  Yes  No

Other \_\_\_\_\_

**Neurological**

Tremors  Yes  No

Dizzy Spells  Yes  No

Other \_\_\_\_\_

**Endocrine**

Excessive Thirst  Yes  No

Too Hot / Cold  Yes  No

Other \_\_\_\_\_

**Cardiovascular**

Chest Pains  Yes  No

High Blood Pressure  Yes  No

Other \_\_\_\_\_

**Hematological/Lymphatic**

HIV positive  Yes  No

Blood Clotting Problem  Yes  No

Other \_\_\_\_\_

**Allergic/Immunological**

Hay Fever  Yes  No

Drug Allergies  Yes  No

Other \_\_\_\_\_

**Psychological**

Are you generally satisfied with life?  Yes  No

Do you feel severely depressed?  Yes  No

Other \_\_\_\_\_

Explain any "Yes" answers in the box below

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What is the reason that you are seeing the doctor today?** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

I have reviewed this form: \_\_\_\_\_

Dr. McClure, Dr. McRackan, or Cheri Elliott, ANP