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MEDICAL HISTORY REPORT

1

Name ____
Last First Middle/Maiden

Address ____

City ____________________ State __________ Zip ______________

Date of Birth ________________ Place of Birth __________________

2

CHECK EACH ITEM YES OR NO

Do you now have or have you ever had:

	Yes	No		Yes	No		Yes	No
1. Asthma			27. Hemorrhoids			10. Decrease in hearing ability		
2. Allergies or hay fever			28. Anemia			11. Frequent earaches or discharge from ears		
3. Bronchitis			29. Cancer			12. Buzzing or ringing in ears		
4. Pneumonia			30. Hodgkins Disease or leukemia			13. Sudden attacks of dizziness		
5. Pleurisy			31. Venereal disease			14. Frequent or severe nosebleeds		
6. Emphysema			32. Polio			15. Frequent headaches severe enough to limit activity		
7. Tuberculosis			33. Malaria			16. Bruise easily		
8. Migraine headaches			34. Nervous or emotional breakdown			17. Bleed excessively after cut or dental extraction		
9. Jaundice			35. Ruptured disc			18. Seen dentist in last year		
10. Hepatitis or other liver disease			36. Hernia			19. Wear dentures		
11. Nephritis or other kidney disease			37. Varicose veins			20. Gums bleed easily		
12. Kidney stones			38. Phlebitis			21. Persistent sore or rough places on lips or tongue		
13. Diabetes			39. Skin problems			22. Persistent change in sense of taste or smell		
14. Gout			40. Hearing loss			23. Frequent or severe sore throats		
15. Arthritis or rheumatism			41. Any other serious illnesses or injuries which required treatment			24. Hoarseness that lasted more than one week		
16. Bursitis			**Do you have any of the following:**			25. Frequent colds		
17. Hypertension (high blood pressure)						26. Chest cold last at least 3 weeks in winter		
18. Stroke			1. Change in skin character or texture			27. Colds usually go to chest		
19. Rheumatic fever			2. Unusual growth on skin			28. Wheezy or whistling chest		
20. Heart murmur			3. Change in color or size of any mole			29. Chronic cough		
21. Heart Attack			4. Swelling or lump in neck, armpits, groin or breasts			30. Cough up blood		
22. Epilepsy/Convulsion/Seizures			5. Wear glasses			31. Short of breath walking at normal pace on level		
23. Thyroid disorder			6. Difficulty with vision not corrected by glasses.			32. Chest pain		
24. Peptic ulcer			7. Blurring of vision			33. Pressure or heaviness		
25. Gallstones			8. Pain or inflammation in eyes			34. Chest pain which radiated down either arm		
26. Colitis or other bowel problem.			9. Color-blindness					

	Yes	No
35. Irregular heartbeat		
36. Abnormal Electrocardiogram		
37. Ankles swell		
38. Sleep propped up in bed		
39. Pain in either leg on walking		
40. Difficulty swallowing		
41. Frequent Nausea or vomiting		
42. Stomach pain		
43. Excessive gas, belching or bloating		
44. Intolerance of fatty foods		
45. Recent change in bowel habits		
46. Diarrhea lasting more than one week		
47. Blood in bowel movement		
48. Black or tarry bowel movements		
49. Constipation		
50. Get up at night to urinate		
51. Trouble starting or stopping your stream when you urinate		
52. Loss of force when you urinate		
53. Frequency, burning or pain when you urinate		
54. Blood, pus, sugar, or albumin in urine		
55. Swelling of any joints		
56. Frequent backaches		
57. Persistent numbness, tingling, weakness or paralysis in any body part		
58. Tremors or shaking of hands		
59. Chills or night sweats		
60. Treatment by X-ray or radiation for any condition		
61. Any other personal or health problems you want to discuss with a physician		
Men Only:		
63. Swelling or lumps in your testicles		
64. Prostate trouble		
65. Discharge from penis		
66. Sore on penis		
Women Only:		
68. Number of times pregnant _____		
69. Now pregnant		
70. Number of miscarriages or abortions _____		
71. Unexplained vaginal bleeding		
72. Unusual or excessive vaginal discharge		
73. Lump in breasts		
74. Discharge or bleeding from nipples		
75. Change in skin of breasts		
76. Examine your breasts at least monthly for lumps		

	Yes	No
77. Pap smear in last year		
78. Menopause (if yes, omit 79-80)		
79. Date of last period / /		
80. Regular periods		
81. Severe pain or cramps during periods		

82. Describe flow:

____ Scant ____ Moderate ____ Heavy

List hospitalizations beginning with most recent and approximate age at the time.

Surgery or illness	Age

MEDICATIONS:

	Y	N
1. Do you take any medications regularly? (including vitamins, hormones, birth control pills, sleeping tablets, etc.) If yes, please list.		

	Y	N
2. Are you allergic to any medications? If yes, please list.		

Family History

Relation	Age	Health	If deceased cause of death	Age at death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				

Has a blood relative every had:

	Yes	No	If yes, relationship
Cancer			
Heart Disease			
Hypertension (high blood pressure)			
Glaucoma			
Diabetes			
Gout			
Committed Suicide			
Emotional, nervous or mental breakdown			
Other serious disease (please specify)			

NAME:

3

PHYSICAL EXAMINATION		Date		Ht In.	Wt. lbs	BP	P
Check Appropriate Column		N	Abn	Number & Describe Abnormalities in Detail			
1. General Appearance							
2. Skin							
3. Head & Neck							
4. Eyes	a. Conjunctive						
	b. Pupils						
	c. Fundi						
5. Ent	a. External Ear						
	b. Tympanic Membrane						
	c. Septum						
	d. Teeth Gums						
	e. Throat Tonsils Tongue						
	f. Trachea						
6. Lymph Nodes							
7. Thyroid	a. Size						
	b. Nodules						
8. Breasts	a. Skin						
	b. Nipples						
	c. Masses						
9. Chest	a. Contour						
	b. Expansion						
10. Lungs	a. Rales						
	b. Rhonchi						
	c. Wheeze						
	d. Dullness						
11. Heart	a. Rate						
	b. Rhythm						
	c. Insp./Palp						
	d. Sounds						
	e. Murmur						
12. Vessels	a. Pulses						
	b. Bruits						
	c. Aorta						
	d. Varicosities						
13. Abdomen	a. Scars						
	b. Tenderness						
	c. Masses						
	d. Hernia						
14. Genitalia							
15. Prostrate							
16. Rectum							
17. Spine	a. Mobility						
	b. Alignment						
18. Extremities	a. Joints						
	b. Deformity						
	c. Edema						

		N	Abn	Number & Describe Abnormalities in Detail
19. Neurological	a. Gait			
	b. Coordination			
	c. Reflexes			
	d. Sensory			
	e. Cranial Nerves			
20. Other				
Comments				

4
LABORATORY

CBC Differential

Urine analysis

SMAC

Mantoux: Results:

X-Ray report (Only if indicated by history)

EKG report (Only if indicated by history)

5
RECOMMENDATIONS FOR PHYSICAL ACTIVITY

Unrestricted

Restricted, list reasons:

General statement of health:

Signature: ______________________________ Date: ______________

Name of Physician: ______________________________

Address: ______________________________

______________________________ Phone: ______________