Medical History and Review of Symptoms

Name: _____Date of Birth: _____ Date: _____

Allergies: _____

Relevant Current History

	Check One		Check One
High blood pressure How many years _____	YES ☐ NO ☐	**Constitutional**	YES ☐ NO ☐
Do you take blood pressure medicine	YES ☐ NO ☐	Weight change	YES ☐ NO ☐
Do you check your BP at home	YES ☐ NO ☐	Fevers	YES ☐ NO ☐
Do you have diabetes For how long _____years	YES ☐ NO ☐	Chills	YES ☐ NO ☐
Nerve damage (numbness or decreased feeling in your feet)	YES ☐ NO ☐	Sweats	YES ☐ NO ☐
Kidney damage	YES ☐ NO ☐		YES ☐ NO ☐
Impotence	YES ☐ NO ☐	**Eyes**	
		Last eye exam date _____	
Cardiovascular		Any damage from diabetes	YES ☐ NO ☐
Chest pain with exertion	YES ☐ NO ☐	Any damage from high Blood Pressure	YES ☐ NO ☐
Any prior heart surgery	YES ☐ NO ☐	Any laser procedure	YES ☐ NO ☐
Any prior cardiac cauterization	YES ☐ NO ☐		
Any prior stress test	YES ☐ NO ☐	**Ears, Nose, Throat**	
Any prior echocardiogram	YES ☐ NO ☐	Dentures	YES ☐ NO ☐
		Hearing difficulty	YES ☐ NO ☐

Gastrointestinal			
Gastrointestinal bleeding	**YES** ☐ **NO** ☐	**Pulmonary**	
Recurrent nausea and vomiting	**YES** ☐ **NO** ☐	Cough	**YES** ☐ **NO** ☐
Prior endoscopy (stomach evaluation	**YES** ☐ **NO** ☐	Smoking Number of packs per day _____	**YES** ☐ **NO** ☐
Prior colonoscopy (bowel evaluation)	**YES** ☐ **NO** ☐	History of asthma or COPD	**YES** ☐ **NO** ☐
Heart burn or indigestion	**YES** ☐ **NO** ☐	Shortness of breath with exertion	**YES** ☐ **NO** ☐
Ulcer disease	**YES** ☐ **NO** ☐		
		Skin	
Neurologic		Rash	**YES** ☐ **NO** ☐
Transischemic attack or mini stroke	**YES** ☐ **NO** ☐	Skin Cancer	**YES** ☐ **NO** ☐
Stroke Date: _____ Location of weakness _____	**YES** ☐ **NO** ☐		
Seizures	**YES** ☐ **NO** ☐	**Musculoskeletal**	
Carotid ultrasound	**YES** ☐ **NO** ☐	Gout	**YES** ☐ **NO** ☐
CT or MRI of the brain	**YES** ☐ **NO** ☐	Muscle aches	**YES** ☐ **NO** ☐
		Joint aches	**YES** ☐ **NO** ☐
Blood or Cancer Problems		**Endocrine**	
Anemia or low blood count	**YES** ☐ **NO** ☐	High or low blood sugar	**YES** ☐ **NO** ☐
History of easy bruising	**YES** ☐ **NO** ☐	Thyroid problems	**YES** ☐ **NO** ☐

Cancer	YES ☐ NO ☐	Pre/post-menopausal	YES ☐ NO ☐
Chemotherapy	YES ☐ NO ☐	Osteoporosis	YES ☐ NO ☐
		Bone density study	YES ☐ NO ☐

Social History

Are you employed	YES ☐ NO ☐	Do you use drugs	YES ☐ NO ☐
Do you use tobacco How many per day _____	YES ☐ NO ☐	Do you drink alcohol How much per day_____	YES ☐ NO ☐

Renal History

Blood in urine	YES ☐ NO ☐	Kidney stones	YES ☐ NO ☐
Protein in the urine	YES ☐ NO ☐	Do you get up at night to urinate How many times? _____	YES ☐ NO ☐
Foamy urine	YES ☐ NO ☐	Do you lose your urine (incontinence)	YES ☐ NO ☐
History of urinary tract, bladder, or kidney infection	YES ☐ NO ☐	Any burning, pain or discomfort urinating	YES ☐ NO ☐
Any kidney x-rays such as ultrasound, IVP or CT scan When _____	YES ☐ NO ☐	Any flank pain (between the ribs and hip)	YES ☐ NO ☐
Prior 24 hour urine test	YES ☐ NO ☐	Swelling of the legs	YES ☐ NO ☐
So you take pain pills, including over the counter	YES ☐ NO ☐	Kidney or bladder surgery	YES ☐ NO ☐

Family Medical History

Anyone with kidney stones	YES ☐ NO ☐	Anyone with high blood pressure	YES ☐ NO ☐

What is the health status of your parents? Or Cause of death if deceased

Mother		Father	

What is the health status of your siblings? Or cause of death if deceased

Sibling 1:		Sibling 2:	

Sibling 3:		Sibling 4:	

What is the health status of your children?

Child 1:		Child 2:	
Child 3:		Child 4:	

Past Medical History- List problems and recent hospitalizations

Past Surgical History – List any surgeries including dates

Prescribed Medications

Name of Medication	**Strength**	**Directions: (i.e. 1 per day at night, 2 every 8 hours)**

Over the Counter Medicine- (Vitamins, Herbal supplements, pain/allergy relief, sleep aid, etc.

Name of Medication	**Strength**	**How often (i.e. one per day, occasionally, etc.**
