Family Medical Center

at

Cinco Ranch

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MEDICAL HISTORY

Name: _____ Date of Birth:_____ Today's Date: _____

SSN: _____ Home Phone: _____ Cell Phone: _____

PAST MEDICAL HISTORY

MEDICATIONS: list all medications, doses, and frequency, including over-the-counter medications

1._____ 8._____

2._____ 9._____

3._____ 10._____

4._____ 11._____

5._____ 12._____

6._____ 13._____

7._____ 14._____

MEDICAL HISTORY: ***Check*** *and* ***indicate age*** *when you had any of the following. Mark* ***C*** *for current problems.:*

Constitutional
- chills
- fatigue
- fever
- night sweats
- weight gain
- weight loss

Eyes
- blurred vision
- eye drainage
- eye pain
- glasses/contacts
- light sensitivity

Ears/Nose/Throat
- ear pain
- hearing problems
- ringing in ears
- frequent nose bleeds
- nasal congestion
- frequent runny nose
- hoarseness
- frequent sore throat
- frequent sinusitis

Hematology/Lymph
- easy bruising/bleeding
- anemia
- blood transfusion
- swollen glands

Cardiovascular
- chest/leg pain
- stroke/heart attack
- heart murmur
- high blood pressure
- fast/slow/irreg heart rate
- shortness of breath: lying flat on exertion
- swollen ankles
- varicose veins

Respiratory
- pneumonia
- cough (acute)
- cough (chronic)
- shortness of breath
- exposure to TB
- coughing up blood
- pain with breathing
- wheezing

Gastrointestinal
- abdominal pain
- acid reflux/heartburn
- loss of appetite
- bloating
- pain with swallowing
- ulcer
- constipation
- diarrhea
- jaundice/hepatitis
- nausea/vomiting
- vomiting blood
- hemorrhoids
- bloody/tarry stools
- colitis
- hernia
- stool caliber change

Genitourinary
- pain with urination
- genital lesions
- blood in urine
- sexually transmitted disease
- unprotected intercourse
- frequent bladder infections
- impotence
- frequent urination
- kidney stones
- urinary incontinence
- urine stream change

Psychiatric
- anxiety
- depression
- feeling stressed
- personality change
- poor concentration
- sleep disturbance
- suicidal thoughts

Musculoskeletal
- arthritis
- back pain
- joint stiffness/pain
- gout
- muscle pain

Neurologic
- fainting/dizzy spells
- headaches
- memory loss
- numbness/tingling
- seizures
- tremor
- vertigo
- weakness

Endocrine
- hair loss/growth
- heat/cold intolerance
- excessive sweating
- increased skin pigment
- infertility
- diabetes
- excessive thirst/eating
- thyroid problems

Allergy/immunology
- allergies/hives
- HIV risk factors
- cancer

Other Medical Diagnosis or Problems not listed:_____

_____

_____

_____

WOMEN'S HEALTH:

Age of first period: _____
Date of last period: _____
Year of menopause: _____
pregnancies: _____
#miscarriages/abortions: _____

□ heavy/irreg periods
□ painful cramps
□ fibroids
□ regular breast exam
□ breast problem

MEN'S HEALTH:

□ regular testicular exam
□ frequent nighttime urination
□ decreased libido
□ erectile dysfunction

MEN AND: □ sexually active with: □ men □ women □ both # partners _____ □ use latex condom
WOMEN type of birth control:_____ STDs: □ genital herpes □ chlamydia □ gonorrhea
□ syphilis □ genital warts □ HPV

ALLERGIES: to medication (list type of reaction) and seasonal
_____
_____

SURGERIES/HOSPITALIZATIONS: list with dates
_____
_____
_____

FAMILY HISTORY: check and indicate which blood relative was affected

□ arthritis	□ epilepsy	□ thyroid disease	□ migraine	_____
□ mental illness	□ glaucoma	□ diabetes	□ hay fever	_____
□ asthma	□ anemia	□ osteoporosis	□ heart disease	_____
□ stroke	□ hypertension	□ hi cholesterol	□ cancer (?type)	_____
□ hepatitis	□ bleeds easily	□ alcoholism	□ other	_____

SOCIAL INFORMATION: mark where applicable
□ tobacco □ current: ____ pack(s)/day since __ __ __ __(year)
□ none □ past: quit in __ __ __ __(year) after ____pack(s)/day for _____ years
□ alcohol □ current: ____ glasses/cans of _____ , _____ times per week
□ none □ past: Quit in __ __ __ __(year) after drinking _____
□ recreational □ current: type:_____
drugs □ none □ past: type:_____
□ exercise □ current: type: _____, _____times per week

IMMUNIZATION HISTORY: list year of most recent vaccination:

Tetanus/Td	_____	Hepatitis B	_____
Influenza	_____	Hepatitis A	_____
Pneumonia	_____	TB skin test	_____ results + / neg

HEALTH MAINTENANCE: list year of most recent examination and results:

annual physical exam	_____	colonoscopy	_____	Bone Density	_____
cholesterol	_____	pap smear	_____	EKG	_____
eye examination	_____	mammogram	_____	stress test	_____
dental examination	_____	PSA	_____		

Do you have a Living Will or Durable Power of Attorney for Healthcare? □ yes □ no
If yes, please attach a copy for your medical records.

Comments:_____
_____
_____
_____

Patient Signature:_____ Date:_____