PAST MEDICAL HISTORY

Name _____ **Medical History** **Age**_____ **Date** _____

Medical ☐ None (Diabetes, Asthma, High blood pressure, Cancer, Heart disease, High Cholesterol, Anxiety, Depression, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

Surgical ☐ None (Tonsillectomy, Appendectomy, Hernia, Gall bladder, Hysterectomy, C-section, Arthroscopy, Colonoscopy, etc.)

_____ _____

_____ _____

Allergies to medications? ☐ None (If Yes, please list drugs and explain type of reaction; i.e. hives, wheezing, upset stomach, etc.)

_____

Current prescription medicines ☐ None

Name of drug	mg dose	# tablets	# times per day

Also -- Vitamins or Herbals

Name of drug or vitamin	mg dose	# tablets	# times per day

Smoke ☐None ☐ Yes, or if previously, _____ # packs/day for _____ # of years. Stopped smoking? Date _____
Alcohol ☐None ☐Rarely ☐Occasional wine with dinner ☐Weekends ☐1-2 drinks per day ☐more than 2 drinks per day
OTC drugs ☐None ☐Aspirin ☐Tylenol ☐Ibuprofen ☐Aleve ☐Tums ☐Maalox ☐Mylanta ☐Pepcid AC ☐Allergy
Exercise ☐None ☐ Yes What and how frequently? _____
Substance Abuse ☐None ☐Marijuana ☐IV Drug abuse Other_____
Seatbelts ☐Use routinely ☐Use occasionally **Helmet** ☐Does not apply ☐Use routinely ☐Use occasionally
Females First menstrual period? _____Years old Last menstrual Period? _____Years old Date of first day of LMP _____

Family History

Father ☐ Living - Age _____ ☐ Deceased, Age at Death _____ (Cause) _____
Mother ☐ Living - Age _____ ☐ Deceased, Age at Death _____ (Cause) _____
Siblings: Number Living _____ Number deceased _____ (Cause)_____
Other illnesses in your family ☐ None (Example - Diabetes, Heart disease, High Blood Pressure, Colon cancer, Breast cancer, Prostate cancer, etc)

_____

Social History

Where were you born and raised? _____ When did you move to Arizona? _____
☐Married_____years ☐Single ☐Widowed ☐Divorced; Spouse's Name _____ Age _____ Healthy? Y N
Kids ☐None Name_____ Age_____ M F, Name_____ Age_____ M F, Name_____ Age_____ M F
Education ☐High School ☐Some College ☐Degree(s) _____
Occupation _____ Religious Preference _____
Special interests or hobbies_____
Do you have Advanced Directives? _____ Durable Power of Attorney for Medical Care? _____

Physician Signature _____**M.D.**

REVIEW OF SYSTEMS

Name _____ **Age**_____ **Date:** _____

Do you now or have you had any problems related to the following systems?
Circle **Yes** or **No.**

Constitutional			**(Comments)**
Weight change	Y	N	
Chills	Y	N	
Night sweats	Y	N	
Other			

Eyes			
Double vision	Y	N	
Glaucoma	Y	N	
Cataracts	Y	N	
Other			

Ear/Nose/Throat			
Hearing changes	Y	N	
Sore throat	Y	N	
Sinus problem	Y	N	
Other			

Cardiovascular			
Chest pain	Y	N	
Irregular heartbeat	Y	N	
Swelling in ankles	Y	N	
Other			

Psychologic			
Do you feel anxious?	Y	N	
Do you feel depressed?	Y	N	
Are you often unhappy?	Y	N	
Other			

Endocrine			
Excessive thirst	Y	N	
Too hot/cold	Y	N	
Tired/sluggish	Y	N	
Other			

Hematologic/Lymphatic			
Swollen glands	Y	N	
Lumps or bumps	Y	N	
Bruising	Y	N	
Other			

Allergic/Immunologic			
Hay Fever	Y	N	
Drug allergies	Y	N	
Food allergies	Y	N	
Other			

Genitourinary			**(Comments)**
Change in stream	Y	N	
Bathroom at night	Y	N	
Blood in urine	Y	N	
Other			

Musculoskeletal			
Bone pain	Y	N	
Muscle pain	Y	N	
Joint pain	Y	N	
Other			

Integumentary (Skin)			
Rash	Y	N	
Lumps or bumps	Y	N	
Moles, skin tags	Y	N	
Other			

Neurological			
Tremors	Y	N	
Dizzy spells	Y	N	
Numbness/tingling	Y	N	
Other			

Respiratory			
Wheezing	Y	N	
Frequent cough	Y	N	
Shortness of breath	Y	N	
Other			

Gastrointestinal			
Abdominal pain	Y	N	
Nausea/vomiting	Y	N	
Indigestion/heartburn	Y	N	
Other			

Sexual History			
Does not apply ☐			
Change in sex drive?	Y	N	
Change in sexual performance?	Y	N	
Other			

Periodic Information

Date - Last Tetanus Shot _____ ☐ More than ten years
Date - Last Eye Exam _____
Date - Last Colon Exam _____
Date - Last Bone Density Exam _____ ☐ Does not apply
Date - Last Female Exam _____ ☐ Does not apply
Date - Last Mammogram _____ ☐ Does not apply

Physician comments

Provider Signature _____ **D.O./CRNP**