COMPREHENSIVE PATIENT MEDICAL HISTORY

Patient Name:_____ **#**_____ **Date:**_____

CURRENT PROBLEM - **What is the main reason for today's exam? A brief description please:**

_____

_____

DO YOU PRESENTLY HAVE **any problems in the following areas? If YES, please give an explanation below**

• EYES	Yes	No	Explanation of Problems		Yes	No	Explanation of Problems
BLURRED VISION				EXCESSIVE TEARING			
FLUCTUATING VISION				DRYNESS			
LOSS OF VISION				REDNESS			
DISTORTED VISION				ITCHING			
DOUBLE VISION				GLAUCOMA			
LOSS OF SIDE VISION				RETINAL DETACHMENT			
GLARE/LIGHT SENSITIVE				CATARACT			
EYE PAIN							Are you having any difficulty?
BURNING				DRIVING AT NIGHT			
SANDY FEELING				READING STREET SIGNS			
MUCOUS DISCHARGE				WRITING CHECKS OR PLAYING CARDS			
FLOATERS-NEW OR OLD				PLAYING GOLF OR TENNIS			
OTHER				WATCHING TV/MOVIES			

MEDICAL HISTORY

Previous Hospitalizations/Surgeries/Serious Injuries – When?

_____

_____

_____

_____

- **Patient Medical History**

Diabetes.....	No	Yes
Hypertension.....	No	Yes
Cancer.....	No	Yes
Stroke.....	No	Yes
Arthritis/Gout...	No	Yes
Heart Trouble....	No	Yes
Convulsions.....	No	Yes
Venereal Disease..	No	Yes
Hereditary Defects.	No	Yes
Bleeding Tendency.	No	Yes
Acute Infection..	No	Yes

MEDICATIONS-Please list current medication, including eye drops - Dosage and frequency. PLEASE bring all medication with you.

_____

_____

_____

_____

_____

DRUG ALLERGIES? **NO or YES - if yes please list.**

_____

_____

- **Patient Social History:** What is your occupation? _____

Marital status: Single___ Married___ Separated___ Divorced___ Widowed____

Use of alcohol: Never____ Rarely____ Moderately____ Daily____

Use of tobacco: Never____ Previously, but quit ____ Current packs/day _____

Use of illegal drugs: Never____ Type/Frequency _____

- **Family Medical History**

	Age	Disease	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
Children	____	_____	_____

OVER-----PLEASE COMPLETE PAGE 2

PAGE 2
SYSTEMS REVIEW continued...
OTHER: _____

_____

- **CONSTITUTIONAL SYMPTOMS**

Good general health lately.....	No	Yes
Ht____ Wt_____ Recent Change?____	No	Yes
Fever.....	No	Yes
Fatigue.....	No	Yes
Headaches.....	No	Yes

- **EAR/NOSE/MOUTH/THROAT**

Hearing loss or ringing.....	No	Yes
Earache or drainage.....	No	Yes
Chronic sinus problem or rhinitis.....	No	Yes
Nose Bleeds.....	No	Yes
Mouth sores.....	No	Yes

- **CARDIOVASCULAR**

Heart trouble.....	No	Yes
Chest pain or angina pectoris.....	No	Yes
Palpitation.....	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands.....	No	Yes

- **RESPIRATORY**

Chronic or frequent coughs.....	No	Yes
Spitting up blood.....	No	Yes
Shortness of breath.....	No	Yes
Asthma or wheezing.....	No	Yes

- **GASTROINTESTINAL**

Loss of appetite.....	No	Yes
Change in bowel movements.....	No	Yes
Nausea or vomiting.....	No	Yes
Frequent diarrhea.....	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool.....	No	Yes
Abdominal pain or heartburn.....	No	Yes
Peptic ulcer (stomach or duodenal).....	No	Yes
Hepatitis A, B non A non B, C.....	No	Yes

- **GENIROURINARY**

Frequent urination.....	No	Yes
Burning or painful urination.....	No	Yes
Blood in urine.....	No	Yes
Kidney disease.....	No	Yes
Prostate cancer.....	No	Yes
Cervical/Uterine cancer.....	No	Yes
Pregnant Now :.....	No	Yes

- **MUSCULOSKELETAL**

Joint pain.....	No	Yes
Joint stiffness or swelling.....	No	Yes
Weakness of muscles or joints.....	No	Yes
Muscle pain or cramps.....	No	Yes
Back pain.....	No	Yes
Cold extremities.....	No	Yes
Difficulty walking.....	No	Yes

PHYSICIAN SIGNATURE ONLY
Reviewed:_____ Date_____
Reviewed:_____ Date_____
Reviewed:_____ Date_____
Reviewed:_____ Date_____

_____

_____

- **INTEGUMENTARY (skin/breast)**

Rash or itching.....	No	Yes
Change in skin color.....	No	Yes
Change in hair or nails.....	No	Yes
Varicose veins.....	No	Yes
Breast pain.....	No	Yes
Breast lump.....	No	Yes
Breast discharge.....	No	Yes

- **NEUROLOGICAL**

Frequent or recurring headaches.....	No	Yes
Light headed or dizzy.....	No	Yes
Convulsions or seizures.....	No	Yes
Numbness or tingling sensations.....	No	Yes
Tremors.....	No	Yes
Paralysis.....	No	Yes
Stroke.....	No	Yes
Head injury.....	No	Yes

- **PSYCHIATRIC**

Memory loss or confusion.....	No	Yes
Nervousness.....	No	Yes
Depression.....	No	Yes
Insomnia.....	No	Yes

- **ENDOCRINE**

Glandular or hormone problem.....	No	Yes
Thyroid disease.....	No	Yes
Diabetes.....	No	Yes
Excessive thirst or urination.....	No	Yes
Heat or cold intolerance.....	No	Yes
Skin becoming dryer.....	No	Yes
Change in hat or glove size.....	No	Yes

- **HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts.....	No	Yes
Bleeding or bruising tendency.....	No	Yes
Anemia.....	No	Yes
Phlebitis.....	No	Yes
Past transfusion.....	No	Yes
Enlarged glands.....	No	Yes
AIDS or HIV.....	No	Yes

- **ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics.....	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics.....	No	Yes
Aspirin or other pain remedies.....	No	Yes
Tetanus antitoxin or other serums.....	No	Yes
Iodine, methiolate or other antiseptics	No	Yes
Latex.....	No	Yes
Other drugs/medications_____	No	Yes
Known food allergies_____	No	Yes