

Breckinridge Family Medical Group

COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Preferred Name: _____ DOB: _____ Date: _____

Current Health Concerns: _____

MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Drug Allergies or Reactions to Medications / Foods / Other Agents: Yes No Please list:

PERSONAL MEDICAL HISTORY: Do you have any of the following?

- Acid Reflux (heartburn)
- Anxiety
- Cancer (list below)
- Chronic Low Back Pain
- Erectile Dysfunction
- Heart Disease (explain below)
- Prostate Problems
- Other Chronic or Recurring Medical Problems (Please list below)
- Alcoholism
- Asthma
- Cholesterol Problem
- Depression
- Gout
- Migraines
- Thyroid Problems
- Allergies (environmental)
- Atrial Fibrillation
- Coagulation (bleeding) Problem
- Diabetes
- High Blood Pressure
- Osteopenia / Osteoporosis

Patient Name: _____ Date: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: Yes No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Have you received a blood transfusion? Yes No When? _____

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history

MEDICAL CONDITION	M	D	B	S	D	S	OTHER CLOSE RELATIVES	MEDICAL CONDITION	M	D	B	S	D	S	OTHER CLOSE RELATIVES
	O	A	R	I	A	O			O	A	R	I	A	O	
	M	D	R	S	U	N			M	D	R	S	U	N	
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

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Patient Name: _____ Date: _____

SOCIAL HISTORY:

Tobacco Use

Please check one

- I have never smoked
- I have smoked, but rarely
When was the last time? _____
- I have quit smoking. Quit Date: _____
How many packs/day? _____ How many yrs? _____
- I currently smoke _____ pack(s)/day.
How many yrs. _____

Other Tobacco: pipe cigar snuff chew

Are you interested in quitting? Y N

Sexual History

Are you sexually active? Y N Not currently

Current sexual partner(s) is/are male female

Birth control method: _____

Have you ever had any sexually transmitted diseases (STD's)? Y N Date: _____ Which STD? _____

Are you interested in being screened for sexually transmitted diseases? Y N

Exercise

Do you exercise? Y N How often? Daily 4 – 6x a week 1 – 3x a week less than one time a week

What form of exercise? (e.g., jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? Y N

Is violence at home a concern for you? Y N

Are you currently in a relationship? Y N

If yes, do you feel safe in this relationship? Y N

Other concerns? _____

Socioeconomics

Marital Status: single married separated divorced widow

Occupation: _____

Education completed: grade school high school college graduate school

Number of children: _____ Who lives at home with you? _____

Frequent foreign travel? Y N Where? _____

Patient Name: _____ Date: _____

Immunizations: Please check any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: Y N _____ Pneumonia: Y N _____ Chicken Pox: Y N _____ Hepatitis A: Y N _____
Hepatitis B: Y N _____ HPV (genital warts): Y N _____ Shingles: Y N _____

REVIEW OF SYSTEMS (please circle any current problems you have on the list below)

General

Fatigue / Weakness
Restless Sleep
Daytime Drowsiness
Unhappiness
Depression / Sadness
Feeling "Blue" or Hopeless for More than 2 wks
Lack of Motivation
Excessive Irritability
Feelings of Worthlessness
Nervous / Anxiety
Unexplained Fever (> 100.0)
Frequent Night Sweats
Unexplained Weight Loss
Unexplained Weight Gain
Excessive Thirst

Skin

Changes in Moles / Unusual Moles
Concerns re: skin spots / rashes / growths
Bruise Easily
Itching
Excessive Hair Growth
Hair Loss

Ears / Nose / Throat

Allergy Symptoms
Hearing Loss
Ringing in the Ears
Dizzy Spells / Dizziness
Nose Bleeds
Sinus Problems
Hoarseness – Frequent

Eyes

Eye Pain
Double Vision / Change in Vision
Itchy / Watery Eyes

Lungs

Cough / Wheeze
Snoring / Gasping at Night During Sleep
Difficulty Breathing
Positive TB Skin Test

Heart

Chest Pain / Pressure
Recent Change in Exercise Tolerance
Heart Murmur
Palpitations / Irregular Pulse
Fainting Spells
Swollen Ankles
Leg Pain with Walking / Exercise

Gastrointestinal

Abdominal Pain
Heartburn / Indigestion
Change in Bowel Habits – Recent
Difficulty Swallowing
Persistent Nausea / Vomiting
Diarrhea / Constipation
Bloody or Black Tarry Stools
Frequent Laxative Use? How Often?

Musculoskeletal

Muscle / Joint Pain
Recurrent or Chronic Back Pain
Joint Swelling
Gout

Genitourinary

Frequent Urine Infections
Painful Urination
Frequent Urination
Urinary Leakage / Incontinence
Blood in Urine
Overnight Urination > 2 x
Sexual Function Problems

Male

Decrease in Force of Urination
Erection Problems
Testicle Lumps / Swelling

Female

Vaginal Discharge / Itching
History of Abnormal Pap Smear
Pain / Bleeding During Sex
Significant Pain / Cramps with Menses
Hot Flashes / Night Sweats

Menstrual History

Age of onset _____ reg. / irreg. / menopause
Flow: heavy / moderate / light
Length of cycle _____ Days of flow _____
of pregnancies _____ # of births _____
of miscarriages / abortions _____

Breast

Pain / Lumps / Discharge

Neurological

Frequent Headaches
Numbness / Tingling
Memory Loss
Tremor / Shaking

Explanation: _____