



Medical History

Patient Intake History

If you feel uncomfortable answering any questions, please leave them blank.
 You may choose to discuss them with the Physician Assistant during your appointment.

Client Name _____	Date of Birth _____
Address _____	City _____ State _____ Zip _____
Home Phone _____	Cell Phone _____
Email address _____	Martial Status <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> divorced <input type="checkbox"/> living with partner
Male <input type="checkbox"/> Female <input type="checkbox"/>	
Primary Care Doctor _____	Other Specialists _____

Past Medical History

Immunizations / History of Infectious Diseases

Have you ever had the following? (please circle)

Measles	Rubella	Mumps	Whooping Cough	Rheumatic fever
Polio	Coxsackie	Chickenpox	Fifth's disease	Scarlet fever
Typhoid	Cholera	Malaria	Hepatitis	STD

	Date		Date
Tetanus-Diphtheria Booster		Varicella Vaccine (chicken pox)	
Influenza Vaccine (flu shot)		Pneumococcal Vaccine	
Hepatitis A Vaccine		Measles/Mumps/Rubella (MMR)	
Hepatitis B Vaccine		Tuberculosis (TB) Skin Test	
		Result + / -	

Adult Illnesses

Major Illness	Yes (date)	No	Unknown	Notes
Asthma				
Lung Disease/ Pneumonia				
Tuberculosis				
Blood Clot in Lungs/Legs				

Thyroid Disease				
Collagen Vascular Disease				
Heart Attack/ Heart Problems				
High Blood Pressure				
Rheumatic Fever				
Anemia				
Blood Transfusion				
Stroke				
Diabetes				
Eating Disorder				
Reflux/ Hiatal Hernia / Ulcers				
Hepatitis/ Liver Disease				
Gallbladder Disease				
Bowel Problems				
Seizures/ Convulsions				
Glaucoma/ Cataracts				
Cancer				
Arthritis/ Joint or Back Problem				
Broken Bones				
Headaches				
Depression/Anxiety				
HIV/ AIDS				
Sexually Transmitted Disease				
Other				

Serious Accidents / Injuries

Type	Date	Type	Date

Operations / Hospitalizations

Reason	Date	Hospital

Current Health Status

Medications

(please include prescription and non prescription medications, vitamins, herbals and supplements)

Drug Name	Dose	Who Prescribed	Drug Name	Dose	Who Prescribed

Known Drug Allergies

Medication	Reaction	Medication	Reaction

Social History

	YES	NO	Notes
Do you use tobacco?			
Do you drink alcohol?			
Recreational drug use?			
Currently dieting?			
Eat fast food?			
Read food labels?			
How much dairy do you eat/drink?			
Do you have food allergies?			
Daily caffeine intake?			
Do you have any diet restrictions?			
Use diet or appetite suppressant pills?			
How often do you exercise?			
Do you lift weights?			
Do cardiovascular exercises?			
How often do you walk for exercise?			
How often do you swim for exercise?			
Have you had any dramatic weight loss or gain?			
Do you have a skin care regimen?			
Do you use any skin care products?			
Do you have regular facials?			
Do you have regular sleeping habits?			
Trouble sleeping?			
Nap during the day?			
Have trouble staying awake?			
Ever take pills to help you sleep?			
Do you have regular/yearly screening exams?			
Tuberculosis testing?			

Pap smears? (if applicable)			
Mammograms? (if applicable)			
Breast exams? (men and women)			
Testicular exams? (if applicable)			
Prostate exams? (if applicable)			
Have your stool tested for blood?			
Cholesterol checked?			
Chest x-ray?			
EKG?			
Blood pressure checked?			
Eye exams?			
Dental exams?			
Health hazards at home or work?			
Do you wear your seatbelt?			
Do you have working smoke or carbon dioxide testers in your home?			
Number of adults living in your home?			
Number of children?			
Number and types of pets?			
Do you have any religious beliefs relating to your perception of your health?			
Have you ever been sexually abused, threatened or hurt physically by anyone?			
Do you travel outside the US?			

Family Medical History

Mother <input type="checkbox"/> living <input type="checkbox"/> deceased – cause: _____	Father <input type="checkbox"/> living <input type="checkbox"/> deceased – cause: _____
Siblings #living _____ #deceased _____ Cause(s)/Age(s) _____	
Children #living _____ #deceased _____ Cause(s)/Age(s) _____	

Illness	Yes	Which relative(s) and age of onset	Notes
Diabetes			
Stroke			
Heart attack			
Heart Disease			
Blood clots in lungs/legs			
High blood pressure			
High cholesterol			
Kidney disease			
Osteoporosis			

Arthritis			
Anemia			
Allergies			
Asthma			
Hepatitis			
Seizures			
Migraines			
HIV/AIDS			
Tuberculosis			
Birth defects			
Breast cancer			
Colon cancer			
Ovarian cancer			
Uterine cancer			
Testicular cancer			
Skin cancer			
Other cancer			
Mental illness			
Depression			
Alzheimer's disease			
Parkinson's			
Drinking or drug problem			
Other			
Other			
Other			

Review of Systems

Please check if any of the following applies now or since adulthood

Constitutional			
Weight gain/loss			
Change in appetite			
Fever / chills			
Fatigue or weakness			
Change in height			
Skin			
Rashes or eruptions			
Dryness			
Sores			
New or changing growths/lumps/moles			
Color or pigment changes			
Itching			

Infection			
Contact sensitivities			
Hair or nail changes			
Sun damage			
Head			
Headache			
Dizziness			
Fainting			
Eyes			
Vision problems			
Wear glasses/contacts			
Pain or burning			
Redness, irritation or itching			
Excessive tearing			
Dryness			
Discharge			
Double or blurry vision			
Spots, floaters or halos			
Flashing lights			
Ears			
Pain or ringing			
Dizziness or spinning			
Infection			
Discharge			
Itching			
Excessive cerumen			
Hearing aid use			
Nose/Sinus			
Frequent colds or sinus infection			
Discharge			
Congestion			
Nose bleeds			
Allergies			
Sensitivities			
Difficulty inhaling or obstruction			
Chronic problems			

Mouth			
Teeth or gum problems			
Sore tongue or lips			
Bleeding			
Ulcers			
Growths			
Change in taste			
Dentures or dental work			
Dry mouth			
Brushing/flossing habits			
Throat			
Sore throat			
Hoarseness			
Difficulty swallowing			
Neck			
Limited range of motion			
Pain or stiffness			
Growths/lumps			
Swollen glands			
Enlarged thyroid/goiter			
Breast			
Lumps (in breasts or under arms)			
Pain or discomfort			
Sores or redness			
Infection			
Nipple discharge			
Changes with period (female)			
Respiratory			
Chronic cough			
Sputum (color quantity)			
Coughing up blood			
Wheezing			
Shortness of breath			
Cardiovascular			
Chest pain or angina			
Difficulty breathing with exertion			
Leg swelling			

Heart murmur			
Palpitations (racing heart)			
Fainting			
Varicose veins			
Leg pains with walking or resting			
Toes/fingers turning blue			
Gastrointestinal			
Change in appetite			
Weight loss/gain			
Food intolerance			
Swallowing difficulties			
Chewing problems			
Heartburn or indigestion			
Excessive burping, bloating or passing gas			
Nausea or vomiting			
Throwing up blood			
Rectal bleeding			
Tarry or discolored stools			
Diarrhea			
Constipation			
Jaundice			
Hemorrhoids			
Hernia			
Ulcers			
Genitourinary			
Urine clarity and color normal			
Burning or painful urinating			
Pus or blood when urinating			
Frequency, urgency, hesitancy			
Incontinence			
Poor stream			
Excessive nighttime urination			
Kidney stones or infections			
Urinary tract infections			

Male Reproductive			
Penile discharge			
Lesions			
Pain or masses			
Hernia			
Fertility problems			
Erectile dysfunction			
Premature ejaculation			
Prostate problems			
Urinary problems			
Scrotal pain or mass			
History of molestation or rape			
Female Reproductive			
Number of pregnancies _____ Deliveries _____ Miscarries _____ Abortions _____			
Premature or multiple births			
Pregnancy problems			
Toxemia			
Age of first period _____			
Last menstrual period ____ / ____ / ____			
Painful periods			
PMS			
Spotting between periods			
Vaginal discharge			
Itching			
Pelvic pain			
Pain with intercourse			
Masses or lumps			
Lesions or rashes			
Problems with reaching orgasm			
History of rape or molestation			
Musculoskeletal			
Muscle pain, stiffness or cramps			
Bone pain, joint pain or stiffness			
Redness around joint			
Swelling limited range of motion			
Muscle weakness			

Backache			
Neurological			
Headache			
Seizures or tremors			
Numbness or tingling			
Poor co-ordination or balance			
Paralysis			
Dizziness or fainting			
Involuntary movements			
Loss of consciousness			
Memory problems			
Speech problems			
Trouble with senses			
Brain or spinal cord infection			
Severe mood changes			
Endocrine			
Thyroid problems			
Heat/cold intolerance			
Excessive thirst or urination			
Flushing of skin			
Excessive sweating			
Hematologic			
Bleeding problems			
Tender or enlarged lymph nodes			
Excessive or easy bruising			
History of blood transfusions			
Psychiatric			
Anxiety			
Nervousness			
Mood swings			
Depression			
Suicidal/homicidal thoughts			
Nightmares or sleeping trouble			
Difficulty thinking clearly			

Paranoia			
Previous hospitalization or counseling			