PATIENT MEDICAL HISTORY

Date: ___/___/___

Name: _____ **Date of Birth:** ___/___/___ **Age:** ____ **Sex:** ____ **Race:** _____

Marital Status: ☐ S ☐ M ☐ Div ☐ Wid ☐ Sep **Occupation:** _____

Referring Diagnosis: _____

REFERRED BY:

☐ Physician ☐ Glendale Memorial Hospital ☐ Family ☐ Friend ☐ Website ☐ Facebook

REFERRING PHYSICIAN: _____

Address: _____ City: _____ State: ____ Zip: _____

PLEASE LIST THE NAMES OF OTHER PHYSICIANS CARING FOR YOU

Primary Care Physician:	Name: _____	City/State: _____
Internist:	Name: _____	City/State: _____
Gastroenterologist:	Name: _____	City/State: _____
Cardiologist:	Name: _____	City/State: _____
Oncologist:	Name: _____	City/State: _____
Other:	Name: _____	City/State: _____

CHIEF COMPLAINT (and duration): _____

HISTORY OF PRESENT ILLNESS: _____

FAMILY HISTORY OF COLON PROBLEMS: _____

FAMILY HISTORY OF ANY TYPE OF CANCER: _____

LIST PERTINENT FAMILY, SOCIAL &/OR PERSONAL HISTORY

Anesthetic Complications: _____

Alcohol: _____

Tobacco: _____

Recreation Drugs: _____

Use This Space for Additional Information

LIST ALL PREVIOUS SURGICAL PROCEDURES & COLONOSCOPIES

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Use This Space for Additional Information

PATIENT LABEL

CHECK APPROPRIATE BOXES – No check means not asked

Have You Ever Had:

☐ Yes	☐ No	☐ ?	Major trauma
☐ Yes	☐ No	☐ ?	Heart attack or heart condition
☐ Yes	☐ No	☐ ?	Stroke/TIA
☐ Yes	☐ No	☐ ?	Alcoholism/Drug Abuse
☐ Yes	☐ No	☐ ?	Diabetes Type I-II
☐ Yes	☐ No	☐ ?	Venereal disease
☐ Yes	☐ No	☐ ?	Communicable disease such as TB, Typhoid fever, Amebiasis, etc.
☐ Yes	☐ No	☐ ?	Hepatitis
☐ Yes	☐ No	☐ ?	MRSA, CDIFF
☐ Yes	☐ No	☐ ?	Blood or plasma transfusion reaction
☐ Yes	☐ No	☐ ?	Horse serum (TAT, GAT) reaction
☐ Yes	☐ No	☐ ?	Penicillin or Sulfa reaction
☐ Yes	☐ No	☐ ?	Anxiety, depression, bipolar
☐ Yes	☐ No	☐ ?	Increased cholesterol
☐ Yes	☐ No	☐ ?	Increased triglycerides
☐ Yes	☐ No	☐ ?	Chronic heart failure
☐ Yes	☐ No	☐ ?	Renal insufficiency/failure
☐ Yes	☐ No	☐ ?	Cancer
☐ Yes	☐ No	☐ ?	Blood thinners
☐ Yes	☐ No	☐ ?	Asthma, emphysema, COPD (chronic Obstructive pulmonary disease)
☐ Yes	☐ No	☐ ?	Autoimmune Disease

Other: _____

_____

WITHIN THE PAST SIX MONTHS, HAVE YOU TAKEN:

☐ Yes	☐ No	☐ ?	Digitalis
☐ Yes	☐ No	☐ ?	Anti-convulsants
☐ Yes	☐ No	☐ ?	Anti-hypertensive agents
☐ Yes	☐ No	☐ ?	Corticosteroids
☐ Yes	☐ No	☐ ?	Narcotics
☐ Yes	☐ No	☐ ?	Blood thinners

IMMUNIZATION HISTORY:

Tetanus	Date: _____
Pneumonia	Date: _____
Influenza	Date: _____
Polio	Date: _____
Measles, Mumps, Rubella	Date: _____
Other	Date: _____

REVIEW OF CURRENT SYMPTOMS: Check appropriate box

GENERAL:

☐ Yes	☐ No	☐ ?	Chills
☐ Yes	☐ No	☐ ?	Fever
☐ Yes	☐ No	☐ ?	Weight Change
☐ Yes	☐ No	☐ ?	Skin Change

YOUR PHARMACY CONTACT INFORMATION:

Pharmacy name: _____

Address: _____

_____

Phone: ( ) _____ Fax: ( ) _____

LIST ALL DRUGS THAT YOU TAKE ROUTINELY

Drug	Dose/Day	How Long

LIST ALL KNOWN DRUG (OR OTHER) ALLERGIES BELOW AND TYPE OF REACTION (I.E.: RASH, ANAPHYLAXIS, SHORTNESS OF BREATH, ETC.)

Drug	Reaction

Use This Space for Additional Information

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT LABEL

Review of Current Symptoms (continued)

EYES:

☐ Yes ☐ No ☐ ? Loss of Vision
☐ Yes ☐ No ☐ ? Double Vision
☐ Yes ☐ No ☐ ? Eye Pain

ENT:

☐ Yes ☐ No ☐ ? Ear Pain
☐ Yes ☐ No ☐ ? Deafness
☐ Yes ☐ No ☐ ? Bleeding Nose
☐ Yes ☐ No ☐ ? Hoarseness
☐ Yes ☐ No ☐ ? Difficulty Swallowing

CARDIORESPIRATORY:

☐ Yes ☐ No ☐ ? Cough
☐ Yes ☐ No ☐ ? Chest pain or Shortness of Breath
☐ Yes ☐ No ☐ ? Blood with Coughing
☐ Yes ☐ No ☐ ? Leg Swelling

GASTROINTESTINAL:

☐ Yes ☐ No ☐ ? Poor Appetite
☐ Yes ☐ No ☐ ? Nausea and Vomiting
☐ Yes ☐ No ☐ ? Constipation or Diarrhea
☐ Yes ☐ No ☐ ? Change in Bowel Habits
☐ Yes ☐ No ☐ ? Jaundice
☐ Yes ☐ No ☐ ? Abdominal Pain
☐ Yes ☐ No ☐ ? Anal Bleeding
☐ Yes ☐ No ☐ ? Anal Pain

GENITOURINARY:

☐ Yes ☐ No ☐ ? Frequency, Urgency, or Incontinence
☐ Yes ☐ No ☐ ? Urgency
☐ Yes ☐ No ☐ ? Blood in Urine
☐ Yes ☐ No ☐ ? Stones or Gravel
☐ Yes ☐ No ☐ ? Urethral Discharge
☐ Yes ☐ No ☐ ? Incontinence

NEUROPSYCHIATRIC:

☐ Yes ☐ No ☐ ? Headaches
☐ Yes ☐ No ☐ ? Seizures
☐ Yes ☐ No ☐ ? Paralysis
☐ Yes ☐ No ☐ ? Anxiety/Depression
☐ Yes ☐ No ☐ ? Disturbance of Gait or Speech
☐ Yes ☐ No ☐ ? Disturbing Feelings or Thoughts

MUSCULOSKELETAL:

☐ Yes ☐ No ☐ ? Back Pain
☐ Yes ☐ No ☐ ? Bone Infections
☐ Yes ☐ No ☐ ? Skeletal Deformities
☐ Yes ☐ No ☐ ? Joint Pain or Swelling
☐ Yes ☐ No ☐ ? Varicose Veins
☐ Yes ☐ No ☐ ? Leg Ulcers

OB-GYN

_____ Pregnancies # _____Vaginal Deliveries #_____ C-Sections

☐ Yes ☐ No ☐ ? Episiotomy – If yes, #_____
☐ Yes ☐ No ☐ ? Non-menstrual bleeding
☐ Yes ☐ No ☐ ? Excessive Menstrual Flow
☐ Yes ☐ No ☐ ? Irregular Menstrual Flow
☐ Yes ☐ No ☐ ? Pelvic Pain

_____ Last Menstrual period

Use This Space for Additional Information

PATIENT LABEL