Sierra Nevada Family Medicine

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Patient Medical History

DATE :_____

NAME:_____ Date of Birth:_____Age:_____Sex (M/F)_____

Address:_____ Phone:_____

Occupation:_____ Employer: _____

Marital Status: □M □ S □ D □ W Children, Ages_____ Spouse's Name:_____

Are you or could you be pregnant? □ Y □ N Who referred you to us?_____

Main Complaint (Why are you here today?) _____

_____

_____

Health History

Do you currently have or have ever had any of the following conditions?

- □ Heart Attack
- □ Heart Disease
- □ Irregular Heartbeat
- □ Heart Murmur
- □ Rheumatic/Scarlet Fever
- □ High Blood Pressure
- □ Anemia Type_____
- □ Bleeds easily
- □ Stroke
- □ Cancer Type_____
- □ Diabetes Type_____
- □ HIV Infection
- □ Migraine Headache
- □ Other Headache
- □ Loss of Consciousness
- □ Convulsions
- □ Numbness/Loss of Sensation
- □ Breast Lump/Cyst
- □ Breast Pain
- □ Nipple Discharge
- □ Osteoarthritis
- □ Osteoporosis
- □ Muscle Pains
- □ Joint Problems
- □ Alzheimer's Disease
- □ Psychiatric Disorders
  - □ Depression
  - □ Anxiety
- □ Renal Disorders
  - □ Kidney Stones
  - □ Kidney Infections
- □ Bladder Infections
- □ Blood in Urine
- □ Unable to Urinate
- □ Painful Urination
- □ Respiratory Disorders
  - □ Asthma
  - □ Tuberculosis
  - □ Bronchitis
  - □ Pneumonia
  - □ Chronic Cough
- □ Seizure Disorder
- □ Thyroid Disorder
- □ Recurrent Sore Throat
- □ Hoarseness
- □ Sexual Transmitted Diseases
- □ Sexual Problems
- □ Irregular Periods
- □ Menopausal Symptoms
- □ Blurred Vision
- □ Loss of Vision
- □ Wear Glasses/Contacts
- □ Hearing Loss
- □ Ringing in Ears
- □ Dizziness
- □ Nosebleeds
- □ Nausea
- □ Vomiting
  - □ Cough Up or Vomit Blood
- □ Stomach Pain
- □ Gall Bladder Disease
- □ Severe/Chronic Constipation
- □ Recurrent Diarrhea
- □ Black/Bloody Stool
- □ Pancreatitis
- □ Liver Disease
  - □ Hepatitis Type_____
  - □ Jaundice

Please list any surgeries you have had (include year)_____

_____

_____

Please list any serious illnesses, injuries, or accidents_____

_____

_____

Date of Last: Period_____ Pap Smear_____ Vaginal Exam_____ Mammogram_____

Prostate Exam_____ Colonoscopy_____ Lab Preference_____

Family History

Has any blood relative ever had any of the following?

	RELATIVE		RELATIVE
Cancer	_____	High Blood Pressure	_____
Lung Disease	_____	Seizures	_____
Diabete	_____	Liver Disease	_____
Heart Disease	_____	Kidney Disease	_____
Stroke	_____	Migraines	_____
Depression	_____	Bleeding Tendency	_____

Social History

Do you currently or have you ever smoked tobacco? □ Y □ N No of Pack/day_____ No of years_____

Alcohol Consumption: □ Never □ Rarely □ 3-5 Drinks/week □ 6-10 Drinks/week □ More than 10/week

Recreational Drug Use: □ Y □ N What drug(s) and how often?_____

Do you exercise? □ Y □ N How many hours/week?_____ Type of exercise _____

Do you sleep well? □ Y □ N Hours/night_____ Do you have a healthy diet? □ Y □ N

History of Present Illness

Do you CURRENTLY have any of the following:

Systemic □ Weight Changes Gain/Loss_____ □ Chills □ Fever □ Feeling Sick	□ Night Sweats **Head** □ Headache □ Facial Pain □ Sinus Pain □ Other_____	**Eye** □ Vision Problems □ Light Sensitivity □ Itchy Eyes Other_____

Mouth/Throat
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Nosebleeds
- ☐ Nasal Discharge
- ☐ Mouth Sores
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Throat Pain
- ☐ Other_____

Neck
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Other_____

Breast
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Breast Lump
- ☐ Other_____

Heart
- ☐ Chest Pain/Discomfort
- ☐ Fast Heart Rate
- ☐ Palpitations
- ☐ Other_____

Lungs
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Other_____

Gastrointestinal
- ☐ Decreased/Increased Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Black or Bloody Stools
- ☐ Other_____

Genitourinary
- ☐ Painful Urination
- ☐ Increased Urinary Frequency
- ☐ Blood in the Urine
- ☐ Genital Lesion
- ☐ Other_____

Skin
- ☐ Itchiness
- ☐ Skin Lesions
- ☐ Rashes
- ☐ Other_____

Endocrine
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Libido Change
- ☐ Other_____

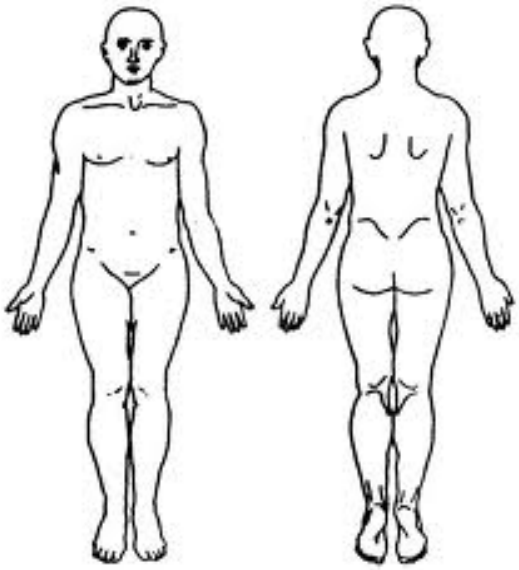
Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Muscles Aches
- ☐ Other_____

Neurological
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting
- ☐ Motor Disturbances
- ☐ Sensory Disturbances
- ☐ Other_____

Psychological
- ☐ Sleep Disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Other_____

Chiropractic Patients Only – Please mark the areas of your symptoms on the figure.

Please use the following symbols: Aches ^^^^^ Numbness +++++ Pins/Needles ***** Stabbing /////



On a scale of 0-10 with 10 being the worst how bad are your symptoms now?_____

How bad have they been?_____

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Date:_____

Patient Name:_____

Date of Birth:_____

Email Address:_____

Local Pharmacy:_____

Mail Order Pharmacy:_____

Drug Allergies:_____

Other Allergies:_____

Current Prescription Medications, Vitamins, and Supplements:

(PLEASE write **"NONE" if not on any Medications, etc…Thank you! ☺)**

Medication	Strength (i.e. 40mg)	Directions (i.e. 2 daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____