

Medical and Family History Form

Name _____ Today's Date _____ Chart # _____

Birthdate _____ Reason For Visit _____

Allergies

None Aspirin Iodine Penicillin Sulfa Versed Eggs Latex Other _____

Past Illnesses

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Stomach/Duod. Ulcer | <input type="checkbox"/> Anemia | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Chronic Pain (>6 mos) | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Frequent Urinary Infections |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> TB or Positive TB skin test | <input type="checkbox"/> Lupus | <input type="checkbox"/> Kidney disease/failure |
| <input type="checkbox"/> Esophagitis/GERD | <input type="checkbox"/> Stroke or Paralysis | <input type="checkbox"/> Arterial Blockages | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Groin Hernia | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Abnormal Blood Clotting | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Emphysema/COPD | |

Previous Operations or Treatments

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> ERCP | <input type="checkbox"/> Ovary | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Capsule Endoscopy | <input type="checkbox"/> Colon Polyp Removal | <input type="checkbox"/> Radiation Therapy-Head/Neck | <input type="checkbox"/> Radiation Therapy-Chest |
| <input type="checkbox"/> Cardiac (CABG) | <input type="checkbox"/> C-Section | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Radiation Therapy-Abdomen | <input type="checkbox"/> Radiation Therapy-Ovary |
| <input type="checkbox"/> Cardiac (Valve) | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Radiation Therapy-Prostate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Groin Hernia | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate Surgery | |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach | |
| <input type="checkbox"/> Upper/EGD | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Thyroid | |

Social History Marital Status:

- Single Separated Married
 Divorced Widowed

Alcohol Use:

- Never Quit
 1 or fewer drinks/week 2 or more drinks/week

Cigarette Use:

- Never Quit
 20 or fewer cigarettes/day More than 1 pack/day

Social History Occupation:

Patient Occupation _____

Veteran

REVIEW OF SYSTEMS

Gastrointestinal:

- | | | | | |
|---|---|--|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Painful Stools | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Flatulence/Rectal Gas | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Dairy Intolerance | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Rectal protrusions | |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mucus in Stools | <input type="checkbox"/> Rectal Urgency | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Soiling/Incontinence | |

Genitourinary:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Burning on Urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Other _____ |

Skin:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Suspicious Lesions |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other _____ |

Cardiovascular:

- | | | |
|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Other _____ |

Neurological:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Other _____ |

Endocrine:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cold Intolerance | |

Constitutional:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Loss of Appetite | |

Psychiatric:

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression | |

Eyes:

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Visual Decline |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Pain | |

Hematologic:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Abnormal Blood Clotting |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prolonged Bleeding | |

Ears, Nose and Throat:

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Other _____ |

Musculoskeletal:

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Joint Pain | |

Respiratory:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Painful Breathing |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Cough | |

FAMILY HISTORY

	Father	Mother	Child(ren)	Brother(s)	Sister(s)
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Please list any prescription medications you currently are taking and how often:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____