Soundview Medical Associates, LLC

PATIENT MEDICAL HISTORY REVIEW

All questions contained here are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I)*: _____ Today's Date: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ M ☐ F DOB: _____

Previous or referring doctor _____ Date of last physical exam _____

MEDICATIONS – List all prescribed drugs and over-the-counter drugs including vitamins, supplements and herbal medicines.

Name of Drug/Supplement	Strength	Frequency Taken

ALLERGIES – to medications or foods. (Check here if none ☐)

Name the Drug/Food	Reaction you had

Immunizations and dates:

Tetanus (if known: ☐ Tdap ☐ Td)	Date: _____	Hepatitis A	Dates (2 shots): _____
Influenza (flu shot)	Date: _____	Hepatitis B	Dates (3 shots): _____
Pheumonia (Pneumovax)	Date: _____	HPV (Gardasil)	Dates (3 shots): _____
Shingles (Zostavax)	Date: _____	MMR (Measels, Mumps, Rubella)	Date: _____
Other:	Date: _____	Polio	Date: _____

Childhood Illness: ☐ Measels ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Have you ever had a blood transfusion? ☐ Yes, year _____ ☐ No

Which of the following conditions are you currently being treated or have been treated for in the past? (Please check all that apply)

☐ Heart disease/Murmur/Angina	☐ Shortness of breath	☐ Eye disorder/Glaucoma	☐ Diabetes
☐ High cholesterol	☐ Asthma	☐ Seizures	☐ Kindey/Bladder problems
☐ High blood pressure	☐ Lung problems/cough	☐ Stroke	☐ Liver problems/Hepatitis
☐ Low blood pressure	☐ Sinus problems	☐ Headaches/migraines	☐ Arthritis
☐ Heartburn (reflux	☐ Seasonal allergies	☐ Neurological problems	☐ Cancer
☐ Anemia or blood problems	☐ Tonsilitis	☐ Depression/Anxiety	☐ Ulcers/colitis
☐ Swollen ankles	☐ Ear problems	☐ Psychiatric care	☐ Thyroid problems

Please provide any additional information to items checked above, or other conditions you have/have had not listed:

_____

_____

_____

_____

SURGERIES

Year	Problem

OTHER HOSPITALIZATIONS

Year	Problem

Please list all other doctors/medical professionals caring for you:

Name	Specialty/Location

HEALTH HABITS AND PERSONAL SAFETY

Occupation: _____

Faith/Religion: _____

Exercise

- ☐ Sendentary (No exercise)
- ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf
- ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.
- ☐ Regular vigorous exercise (i.e., work or recreations 4x/week for 30 min)

Diet

Any dietary restrictions (meat, dairy, etc.) ☐ Yes ☐ No

If yes list: _____

Are you dieting? ☐ Yes ☐ No If yes, describe your diet: _____

Number of meals you eat in an average day? _____

Salt intake ☐ Hi ☐ Med ☐ Low Fat intake: ☐ Hi ☐ Med ☐ Low Caffeine: None Number of cups/cans per day?

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? _____ How many drinks per week? _____

Are you concerned about the amount you drink? ☐ Yes ☐ No

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced blackouts? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Tobacco

Any current tobacco use? ☐ Yes ☐ No

Any history of tobacco use? ☐ Yes ☐ No Or year quit: _____

☐ Cigarettes – Amount/day: ☐ Other (Chew, Pipe, Cigars) – amount/day: Number of years:

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Drugs
Do you currently use recreational or street drugs? ☐Yes ☐No what: _____
Have you ever used street drugs with a needle? ☐Yes ☐No

Sex
Are you sexually active? ☐Yes ☐No
If yes, are you trying for a pregnancy? ☐Yes ☐No
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐Yes ☐No

Personal Safety
Do you live alone? ☐Yes ☐No
Do you have an Advance Directive or Living Will? ☐Yes ☐No
Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐Yes ☐No

FAMILY HEALTH HISTORY

		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Sibling	☐M ☐F		
	☐M ☐F		
	☐M ☐F		
	☐M ☐F		
	☐M ☐F		

		AGE	SIGNIFICANT HEALTH PROBLEMS
Children	☐M ☐F		
	☐M ☐F		
	☐M ☐F		
Grandmother *Paternal*			
Grandfather *Paternal*			
Grandmother *Maternal*			
Grandfather *Maternal*			

Any relatives with colon cancer? ☐Yes ☐No If yes, relationship and age diagnosed:
Any relatives with breast cancer? ☐Yes ☐No If yes, relationship and age diagnosed:
Any relatives with prostate cancer? ☐Yes ☐No If yes, relationship and age diagnosed:
Any relatives with heart disease, heart attack or heart surgery before age 55? ☐Yes ☐No If yes, relationship and age diagnosed:
Other Family History:

WOMEN ONLY

Name of your OB/GYN doctor: _____
Date of last PAP exam: _____
Any abnormal findings? ☐Yes ☐No
If yes, explain: _____
Are you pregnant or breastfeeding? ☐Yes ☐No
Age at onset of menstruation: _____ Period every_____days
Date of last menstruation: _____
Flow: ☐Heavy ☐Average ☐Light
Irregularity or Spotting? ☐Yes ☐No
Number of pregnancies _____ Number of live births _____
Any problems during pregnancy? ☐No ☐Hypertension
☐High blood sugar (gestational diabetes) ☐Other:

MEN ONLY

Date of last prostate and rectal exam: _____
Do you usually get up to urinate during the night? ☐Yes ☐No
If yes, # of times _____
Has the force of your urination decreased? ☐Yes ☐No
Do you have any problems emptying your bladder completely? ☐Yes ☐No
Any difficulty with erection or ejaculation? ☐Yes ☐No
Any testicle pain or swelling? ☐Yes ☐No

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OTHER PROBLEMS

Check if you CURRENTLY have any of the following symptoms to a significant degree and briefly explain

General: ☐ Fevers ☐ Night sweats ☐ Chills ☐ Fatigue ☐ Weight gain ☐ Weight loss

Explain:

Eyes: ☐ Decreased vision ☐ Blurry vision ☐ Eye pain ☐ Dry eyes ☐ Wear glasses or contacts

Explain:

Head/Neck: ☐ Hearing loss ☐ Ear ringing ☐ Nasal congestion ☐ Hoarseness ☐ Difficulty swallowing ☐ Dental problems

Explain:

Chest/Heart: ☐ Chest pain or pressure ☐ Palpitation ☐ Leg swelling ☐ Circulation problems

Explain:

Lungs: ☐ Cough ☐ Shortness of breath ☐ Spitting up blood ☐ Wheezing ☐ Snoring

Explain:

Digestion: ☐ Loss of Appetite ☐ Heartburn ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Change in bowel habits ☐ Hemorrhoids ☐ Blood in stool

Explain:

Genital/Urinary: ☐ Urinary changes ☐ Painful urination ☐ Bloody urine ☐ Difficulty urinating ☐ Nighttime urination ☐ Urinary leakage/incontinence
☐ Urethral or vaginal discharge ☐ Menstrual pain or symptoms ☐ Genital sores or pain ☐ Sexual difficulty, pain or concern

Explain:

Muscles/Joints: ☐ Back pain ☐ Joint pain ☐ Muscle pain ☐ Leg pain

Explain:

Skin: ☐ Rashes ☐ Itching ☐ Sores ☐ Nail changes ☐ Changing moles ☐ Hair loss ☐ Breast pain, lumps or discharge

Explain:

Neurologic: ☐ Frequent/recurrent headache ☐ Fainting ☐ Weakness ☐ Dizziness ☐ Numbness/tingling ☐ Tremors ☐ Seizures

Explain:

Psychiatric: ☐ Anxiety ☐ Depression ☐ Memory problems ☐ Sleep difficulty ☐ Anger problems ☐ Confusion

Explain:

Endocrine: ☐ Excess thirst ☐ Excessive urination ☐ Hot flashes

Explain:

Blood/Lymph: ☐ Unusual bruising ☐ Heavy bleeding ☐ Blood clots ☐ Swollen glands

Explain:

Other problems:

MENTAL HEALTH

Over the past two weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No

Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

PREVENTATIVE HEALTH

Colonoscopy? ☐ Yes ☐ No If yes, date: _____ Location: _____

Mammogram? ☐ Yes ☐ No If yes, date: _____ Location: _____

Bone density test (DEXA)? ☐ Yes ☐ No If yes, date: _____ Location: _____

Prostate Cancer Screening (PSA)? ☐ Yes ☐ No If yes, date: _____

Cholesterol Screening? ☐ Yes ☐ No If yes, date: _____

Eye exam? ☐ Yes ☐ No If yes, date: _____

Dermatology Exam? ☐ Yes ☐ No If yes, date: _____