

BREVARD FAMILY PRACTICE @Transylvania Regional Hospital

Medical History Form

Name: _____ **Today's Date:** _____ **Date of Birth:** _____

Patient Medical History: Previous hospitalizations/surgeries/serious injuries (include dates): _____

| | | | |
|------------------------|----|-----|---|
| Diabetes | No | Yes | _____ |
| High Blood Pressure | No | Yes | _____ |
| Cancer | No | Yes | _____ |
| Stroke | No | Yes | _____ |
| Heart Trouble | No | Yes | _____ |
| Arthritis/Gout | No | Yes | _____ |
| Seizures | No | Yes | Other medical illnesses: _____ |
| Bleeding Tendency | No | Yes | _____ |
| Recent Infection (STD) | No | Yes | Obstetrical History: |
| Venereal Disease | No | Yes | Total number of times pregnant: _____ |
| Hereditary Disease | No | Yes | Total number of deliveries: _____ |
| High Cholesterol | No | Yes | Total number of miscarriages/abortions: _____ |
| Phlebitis/Blood Clots | No | Yes | _____ |
| Asthma/Emphysema | No | Yes | _____ |
| Mental Health Problems | No | Yes | _____ |
| Allergy to Medicines | No | Yes | If yes, name of medication and allergic reaction experienced: _____ |

Please list all prescription and over the counter medications, vitamins, and/or herbs currently taking (name, dosage, and directions):

- | | | | |
|----------|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ | 7. _____ |
| 2. _____ | 4. _____ | 6. _____ | 8. _____ |

Patient Social History:

| | | | | | |
|--------------------------------------|-----------------|----------------------|-----------------|---------------------|--|
| Marital Status | _____ Single | _____ Married | _____ Separated | _____ Divorced | _____ Widowed |
| Use of Alcohol | _____ Never | _____ Rarely | _____ Moderate | _____ Daily | How Much _____ |
| Use of Tobacco (Including Smokeless) | _____ Currently | _____ Previously | _____ Never | Packs Per Day _____ | |
| Use of Drugs | _____ Never | Type/Frequency _____ | | | |
| Place of Employment | _____ | Occupation _____ | | | |
| Past Place of Employment | _____ | Occupation _____ | | | |
| Excessive Exposure at Home/Work To | _____ Fumes | _____ Dust | _____ Noise | _____ Smokers | _____ Solvents _____ Air-Borne Particles |

Family Medical History:

| | Age | Diseases | If Deceased, Cause of Death | Age at Death |
|-------------------------|-------|----------|-----------------------------|--------------|
| Father: | _____ | _____ | _____ | _____ |
| Mother: | _____ | _____ | _____ | _____ |
| Spouse: _____ NAME | _____ | _____ | _____ | _____ |
| Sibling(s): Circle One | | | | |
| Brother / Sister | _____ | _____ | _____ | _____ |
| Brother / Sister | _____ | _____ | _____ | _____ |
| Brother / Sister | _____ | _____ | _____ | _____ |
| Children: _____ NAME | _____ | _____ | _____ | _____ |
| _____ NAME | _____ | _____ | _____ | _____ |
| _____ NAME | _____ | _____ | _____ | _____ |

Any family history of cancer? NO YES (If yes, list type of cancer and relationship to you.) _____
Any family history of diabetes? NO YES (If yes, note relationship to you.) _____
Any family history of stroke or heart disease? NO YES (If yes, note relationship to you.) _____

Immunizations (list dates):

Hepatitis B (date series completed): _____
Td - Adult Tetanus Toxoid (include dates): _____
Influenza (include dates): _____
Pneumovax (include dates): _____
PPD - Tuberculin Skin Test (include date/results): _____

Please list names of other physicians you see in our area (including specialists): _____

DO YOU CURRENTLY HAVE OR HAVE YOU RECENTLY HAD:

CONSTITUTIONAL SYMPTOMS

| | | |
|----------------------------|----|-----|
| Good General Health Lately | NO | YES |
| Recent Weight Change | NO | YES |
| Fever | NO | YES |
| Fatigue | NO | YES |
| Headaches | NO | YES |

EYES

| | | |
|-----------------------------|----|-----|
| Eye Disease/Injury | NO | YES |
| Wear Glasses/Contact Lenses | NO | YES |
| Blurred/Double Vision | NO | YES |
| Glaucoma | NO | YES |

EARS/NOSE/MOUTH/THROAT

| | | |
|--------------------------------|----|-----|
| Hearing Loss/Ringing | NO | YES |
| Earaches/Drainage | NO | YES |
| Chronic Sinus Problem/Rhinitis | NO | YES |
| Nose Bleeds | NO | YES |
| Mouth Sores | NO | YES |
| Bleeding Gums | NO | YES |
| Bad Breath/Bad Taste | NO | YES |
| Sore Throat/Voice Change | NO | YES |
| Swollen Glands in Neck | NO | YES |

CARDIOVASCULAR

| | | |
|--|-------|-----|
| Heart Trouble | NO | YES |
| Chest Pain/Angina Pectoris | NO | YES |
| Palpitation | NO | YES |
| Short of Breath, While Walking or Lying Flat | NO | YES |
| Swelling of Feet, Ankles, or Hands | NO | YES |
| Date of Last Cholesterol Check | _____ | |

RESPIRATORY

| | | |
|-------------------------|----|-----|
| Chronic/Frequent Coughs | NO | YES |
| Spitting Up Blood | NO | YES |
| Shortness of Breath | NO | YES |
| Asthma or Wheezing | NO | YES |

GASTROINTESTINAL

| | | |
|--------------------------------------|----|-----|
| Loss of Appetite | NO | YES |
| Change in Bowel Movements | NO | YES |
| Nausea or Vomiting | NO | YES |
| Frequent Diarrhea | NO | YES |
| Painful Bowel Movements/Constipation | NO | YES |
| Rectal Bleeding or Blood in Stool | NO | YES |
| Abdominal Pain Heartburn | NO | YES |
| Peptic Ulcer (Stomach or Duodenal) | NO | YES |
| Flex Sig., Colonoscopy, EGD | NO | YES |
| Black/Tarry Stools | NO | YES |

PSYCHIATRIC

| | | |
|--------------------------|----|-----|
| Memory Loss or Confusion | NO | YES |
| Nervousness | NO | YES |
| Depression | NO | YES |
| Insomnia | NO | YES |

MUSCULOSKELETAL

| | | |
|----------------------------|----|-----|
| Joint Pain | NO | YES |
| Joint Stiffness/Swelling | NO | YES |
| Weakness of Muscles/Joints | NO | YES |
| Muscle Pain/Cramps | NO | YES |
| Back Pain | NO | YES |
| Cold Extremities | NO | YES |
| Difficulty in Walking | NO | YES |

SKIN

| | | |
|----------------------|----|-----|
| Rash or Itching | NO | YES |
| Change in Skin Color | NO | YES |
| Change in Hair/Nails | NO | YES |
| Varicose Veins | NO | YES |
| Breast Pain | NO | YES |
| Breast Discharge | NO | YES |
| Unusual Moles | NO | YES |

NEUROLOGICAL

| | | |
|------------------------------|----|-----|
| Frequent/Recurring Headaches | NO | YES |
| Light Headed/Dizzy | NO | YES |
| Convulsions/Seizures | NO | YES |
| Numbness/Tingling Sensations | NO | YES |
| Tremors | NO | YES |
| Paralysis | NO | YES |
| Stroke | NO | YES |

Patient's Name (Please Print)

Date

****CONTINUED ON BACK OF THIS PAGE****

ENDOCRINE

| | | |
|-------------------------------|----|-----|
| Glandular or Hormone Problem | NO | YES |
| Thyroid Disease | NO | YES |
| Diabetes | NO | YES |
| Excessive Thirst or Urination | NO | YES |
| Heat/Cold Intolerance | NO | YES |
| Skin Becoming Dryer | NO | YES |
| Change in Hat or Glove Size | NO | YES |

GENTOURINARY

| | | |
|---|-------|-------|
| Frequent Urination | NO | YES |
| Burning or Painful Urination | NO | YES |
| Blood in Urine | NO | YES |
| Change in Force of Stream When Urinating | NO | YES |
| Incontinence or Dribbling | NO | YES |
| Kidney Stones | NO | YES |
| Sexual Difficulty | NO | YES |
| History of Sexually Transmitted Diseases Such as HIV, Syphilis, Genital Warts, Gonorrhea, Herpes, Chlamydia, etc. | NO | YES |
| Male - Testicle Pain | NO | YES |
| Female - Pain with Periods | NO | YES |
| Female - Irregular Periods | NO | YES |
| Female - Vaginal Discharge | NO | YES |
| Female - Date of Last Pap Smear | _____ | _____ |
| Female - Any History of Abnormal Pap Smears | NO | YES |
| Female - Date of Last Mammogram | _____ | _____ |
| Female - Date of Beginning of Last Menstrual Period | _____ | _____ |

HEMATOLOGIC/LYMPHATIC

| | | |
|-------------------------------|----|-----|
| Slow to Heal After Cuts | NO | YES |
| Bleeding or Bruising Tendency | NO | YES |
| Anemia | NO | YES |
| Phlebitis | NO | YES |
| Past Transfusion | NO | YES |
| Enlarged Glands | NO | YES |

ALLERGIC/IMMUNOLOGIC

| | | |
|--|----|-----|
| History of skin reaction or other adverse reaction to: | | |
| Penicillin/Other Antibiotics | NO | YES |
| Morphine, Demerol, or Other Narcotics | NO | YES |
| Novocain or Other Anesthetics | NO | YES |
| Aspirin or Other Pain Remedies | NO | YES |
| Tetanus Antitoxin or Other Serums | NO | YES |
| Iodine, Merthiolate, or Other Antiseptics | NO | YES |
| Other Drugs/Medications (please list): | | |

Known food allergies:

If your answer was "Yes" to any reactions to medications, what kind of reaction did you have to that drug?

Patient's Name (Please Print)

Patient's Signature

Date