COMPREHENSIVE MEDICAL HISTORY FORM

Please complete. This is a confidential part of your medical record and it will be scanned, then shredded. The digital copy will be kept in our e-file library as a permanent part of your electronic medical record. All the information contained in this form, throughout all the three pages, **WILL NOT BE** released to any person(s) or entity (ies) without your written authorization and consent as mandated by HIPAA and medical privacy laws and etiquettes.

NAME _____**AGE** _____ **RACE** _____ **GENDER** _____

DATE OF BIRTH _____ **/** _____ **/**_____

PAST MEDICAL HISTORY: Approximate Date of Diagnosis

- _____
- _____
- _____
- _____
- _____

PAST SURGICAL HISTORY: **Surgeries or operations** you have had in the past.

Type Date Complications if any

- _____
- _____
- _____
- _____
- _____

ALLERGIES: Please circle what you are allergic to. If not allergic to anything CIRCLE **NONE**

- Penicillin Sulfa IV Dye Iodine Shell fish or seafood ACE-Inhibitors
- Describe the reaction:

_____

List **ANY other** substances to which you are **ALLERGIC** to and are not mentioned above.
Please, describe the reaction: _____

HAVE YOU USED ARTHRITIS and PAIN MEDICATIONS: NSAIDS: _____

HAVE YOU USED PROTON PUMP INHIBITORS: PPIs: Heartburn or ULCER MEDICATIONS: _____

NAME AND SIGNATURE: _____ DATE: _____ (TVN-MH-113019)

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SOCIAL HISTORY:

1- Current Occupation: _____
If retired, please list previous occupation: _____

2- Marital Status: __ Married ___ Divorced ___ Living with someone ___ Single ____ Widowed

3-Habits:

Smoking I do not smoke and have never smoked _____
I do not smoke now but used to smoke _____ Packs per day _____
For how many years? _____ Date you quit _____
I **presently** smoke _____ pack(s) per day for the past _____ years.

Alcohol Do you consume alcoholic beverages now? (Circle one) Yes No Prefer not to answer
Have you ever had a "drinking" problem"? (Circle one) Yes No Prefer not to answer

Drugs Do you currently use **OR** have you ever used recreational or intravenous drugs?
(Circle one) Yes No Prefer not to answer

4-Occupational or chemical exposures and world travel:

_____

FAMILY HISTORY:

	If Living		**If deceased**	
	Current age	Medical problems	Age and year of death	Cause of death
Father				
Mother				
Brothers				
Sisters				
Children				

_____

Have any of your immediate blood relatives ever had: Check if **YES? Who**_____
Heart Disease _____ Sickle Cell Disease _____ Diabetes_____ Stroke_____ Kidney Disease_____
Dialysis_____ High Blood pressure _____ Polycystic Kidney Disease_____ Cancer_____

MEDICATIONS: Please list the name, dose and frequency. You may use additional sheet if more space is needed.

- _____
- _____
- _____

Please, list all over the counter medications, especially arthritis medications, such as NSAIDS, herbal medications, or (**AMT**s "**A**lternative **M**edical **T**herapies") or natural remedies. **If none circle: NONE**

Are you up to date on your IMMUNIZATIONS? **YES** **NO** **DO NOT KNOW** **(circle one)**
___ Flu ___ Pneumonia ___ Hepatitis B ____ Tetanus ____ Zoster
Do you EXCERCISE regularly? **YES** **NO** **Prefer not to answer** **(circle one)**

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REVIEW OF SYSTEMS: Please, check ✔ **YES or NO BOX** if you **currently** have or **recently** had the following:

Problem	YES	NO	Problem	YES	NO
Recent unintentional weight changes			Lupus		
Poor appetite			Stomach pains or Ulcers		
Recurrent Fevers or night sweats			Acid reflux or heart burns		
Spots before eyes or Diabetic eye disease			Nausea or vomiting		
Blurred, double vision			Hiatal hernia		
Ringing in ears			Bloody or black tarry Stools		
Mouth sores, ulcers or thrush			Diverticulitis		
Difficulty or painful swallowing			Hemorrhoids		
Nosebleeds			History of internal bleeding		
Frequent or severe headaches			Hepatitis C and/or yellow Jaundice		
Sinus trouble			Chronic Diarrhea		
Coughing up blood			Gallbladder Problems		
Asthma or wheezing			Colitis		
Snoring or sleep apnea			Constipation		
Bronchitis or emphysema			Dribbling at the end of urination		
Swelling of your legs and/or ankles			Trouble emptying bladder		
Shortness of breath			Wake up at night to urinate, how many times		
Chest pains or angina			Lose urine control on coughing or sneezing		
Dizziness or fainting spells			Kidney Stones, if yes which side		
Persistent Cough			Difficulty starting urine		
Heart Attacks or Myocardial Infarctions			Blood in urine		
Wake up at night with shortness of breath			Anemia		
Leg cramps on walking			Blood Clot in legs or lungs		
Irregular Heartbeat, palpitations			Easy bruising		
Congestive Heart Failure			Prolonged bleeding or free bleeder		
Weakness or numbness one side of body			Previous blood transfusion		
Stroke or TIA			Enlarged glands or lymph nodes		
Tingling in feet and/or hands			Skin rashes or lesions		
Memory Loss			AIDS or HIV Positive		
Diabetes			Changes in your hair, greying or thinning		
Thyroid disease			Skin Problems		
Are you excessively thirsty			Joint pains or Arthritis?		
Gout			Back Pains		
For women: Irregular or heavy periods			Muscle aches		
For Men: Erectile Dysfunction			OTHER:		

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