Yale NewHaven Health Northeast Medical Group

PATIENT MEDICAL HISTORY

Today's Date: _____ Date of Birth: _____

Name: _____
Last First Middle

Medical History

Have you ever had any of the following medical problems?

CONDITION	√	DATE	CONDITION	√	DATE	CONDITION	√	DATE
ADHD			Enlarged Prostate			Obesity		
Allergies			Enlarged Thyroid/Goiter			Pain, chronic		
Alzheimer's			Fibromyalgia			Parkinson's Disease		
Anemia			Fainting			Peripheral vascular dz		
Anxiety Disorder			GERD			Positive TB test		
Arthritis			Glaucoma			Prostatitis, chronic		
Asthma			Gout			Psoriasis		
Atrial fibrillation			Hearing loss			Rheumatic fever		
Back pain			Hematuria			Rheumatoid arthritis		
Bipolar d/o			Hemorrhoids			Schizophrenia		
Bleeding d/o			Hepatitis C			Seizures		
Blood clot, leg			High Blood Pressure			Sinusitis, chronic		
Cancer - Breast			High Cholesterol			Sleep d/o		
Cancer – Prostate			HIV Disease			Sciatica		
Cancer –Type:			Hyperthyroidism			Stroke		
Cataract			Hypothyroidism			Substance Abuse		
Congestive Heart Failure			Irregular Heart Beat			TIA		
COPD/Emphysema			Irritable Bowel Syndrome			Tuberculosis		
Coronary Art Disease			Insomnia			Ulcer		
Crohn's Disease			Intestinal Bleed			Ulcerative Colitis		
Depression			Kidney Failure			Underweight		
Diabetes Mellitus I			Kidney Infection			Urinary incontinence		
Diabetes Mellitus II			Kidney Stones			Vein problems		
Diverticulitis Colon			Liver Failure			Venereal disease		
Dizziness/Vertigo			Migraine					
Eating Disorder			Multiple Sclerosis					
Emphysema			Neuropathy					
Other:			Other:			Other:		

Name: _____ Date of Birth: _____
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Surgical History

Have you ever had any of the following medical procedures?

SCREENING PROCEDURE	DATE	LOCATION / RESULT
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density/DEXA		
Prostate Cancer Screen		
Pneumonia vaccine		
Influenza vaccine		
Tetanus shot		
EYE/EAR/NOSE/THROAT	**DATE**	**TYPE / SURGEON / HOSPITAL**
Cataract Surgery		
Laser Eye Surgery		
Tonsillectomy		
Tympanostomy Tube		
HEART	**DATE**	**TYPE / SURGEON / HOSPITAL**
Angioplasty		
Coronary Bypass		
Pacemaker/Defibrillator		
BREAST/LUNG:	**DATE**	**TYPE / SURGEON / HOSPITAL**
Breast Surgery		
Lung Surgery		
Pacemaker/Defibrillator		
GASTROINTESTINAL	**DATE**	**TYPE / SURGEON / HOSPITAL**
Appendectomy		
Cholecystectomy (Gall bladder)		
Other		
REPRODUCTIVE	**DATE**	**TYPE / SURGEON / HOSPITAL**
Colposcopy		
Conization of cervix/LEEP		
Cesarean Section		
Hysterectomy		
Vasectomy		
Other		
JOINT/SPINAL/BRAIN	**DATE**	**TYPE / SURGEON / HOSPITAL**
Joint Surgery		
Spinal Surgery		
Brain Surgery		
SKIN	**DATE**	**TYPE / SURGEON / HOSPITAL**
Skin Surgery		
ENDOCRINE	**DATE**	**TYPE / SURGEON / HOSPITAL**
Thyroid Surgery		
Other		
OTHER	**DATE**	**TYPE / SURGEON / HOSPITAL**
Other (Type):		
Other (Type):		

Name: _____ Date of Birth: _____
Last First Middle

Are you experiencing any of the following symptoms?

NO	YES	CONSTITUTIONAL	NO	YES	BREAST	NO	YES	MUSCULOSKELETAL
		Fatigue			Discharge from nipple			Neck stiffness
		Weight loss			Breast tenderness			Neck pain
		Weight gain			Breast mass			Back stiffness
		Fever	NO	YES	GASTROINTESTINAL			Back pain
		Chills			Loss of appetite			Joint swelling
NO	YES	EYES			Trouble eating			Joint pain
		Double vision			Abdominal Pain			Limitation of joint movement
		Blurred vision			Nausea			Muscle pain
		Sensitivity to light			Vomiting	NO	YES	SKIN
		Reduced vision			Change in bowel habits			
		Eye redness			Diarrhea			Skin rash/lesion
		Eye itching			Constipation			Dry/itchy skin
		Eye pain			Blood in stool			Nail problem
NO	YES	EARS	NO	YES	GENITAL/URINARY	NO	YES	NEUROLOGIC
		Ear discharge			Pain when urinating			Headache
		Ear pain			Blood in urine			Dizziness
		Tinnitus			Discharge			Lightheadedness
		Hearing loss			Dribbling of urine			Fainting
NO	YES	NOSE/THROAT			Frequent urinating at night			Dizziness/Vertigo
		Nasal congestion			Testicular mass			Weakness
		Nasal discharge			Testicular pain			Numbness/Tingling
		Postnasal drip			Problems with erections			Tremor
		Sneezing	NO	YES	HEMATOLOGIC, LYMPHATIC	NO	YES	PSYCHIATRIC
		Epistaxis			Swollen glands			Difficulty Sleeping
		Sore throat			Lymph node tenderness			Mood swings
		Bleeding gums			Anemia			Feeling anxious
		Hoarseness			Bruise easily			Feeling depressed
NO	YES	RESPIRATORY			Bleed easily			Confusion
		Shortness of breath						Memory loss
		Cough				NO	YES	ENDOCRINE
		Coughing up blood						Hungry frequently
		Wheezing						Drinking a lot
		Pain with breathing						Urinating a lot
NO	YES	CARDIOVASCULAR						Enlarged thyroid
		Chest pain						Intolerant of cold
		Palpitations						Intolerant of heat
		Irregular heart beat				NO	YES	ALLERGIC, IMMUNOLOGIC
		Shortness of breath lying down						Hives
		Swelling						Susceptibility to infections
		Pain in legs when walking						Wound healing impairment

Name: _____ Date of Birth: _____
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FAMILY HISTORY				
CARDIOVASCULAR	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Heart Attack / Heart disease				
High Cholesterol				
High Blood Pressure				
Sudden Death				
ENDOCRINE	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Diabetes Mellitus				
Thyroid Disorder				
Other endocrine problem:				
EYES/EARS/NOSE/THROAT	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Glaucoma				
Hearing Problems				
Visual Problems				
GENITAL/URINOLOGY	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Endometriosis/ Ovary/Uterine Disease				
Kidney/Bladder Disease				
Problems with Pregnancy				
HEMATOLOGIC	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Bleeding/blood Disorder				
Sickle Cell Anemia				
MENTAL HEALTH/SUBSTANCE ABUSE	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Attention Deficit Disorder				
Alcoholism or Substance Abuse				
Bipolar Disorder				
Depression				
Schizophrenia				
MUSCULOSKELETAL	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Osteoarthritis				
Osteoporosis				
Rheumatoid Arthritis / Lupus				
NEUROLOGIC	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Alzheimer's Disease / Dementia				
Migraine				
Stroke				
CANCER	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Breast Cancer				
Colorectal/stomach/intestine Cancer				
Endometrial/Ovarian Cancer				
Lung Cancer				
Prostate Cancer				
Skin Cancer/Melanoma				
Cancer-Other				
RESPIRATORY	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Asthma				
Pulmonary Embolism				
Respiratory Disorder				
Tuberculosis				
OTHER	**YES**	**NO**	**FAMILY MEMBER**	**AGE OF ONSET**
Other problems of any type				
Genetic/Birth Defects				

Name: _____ Date of Birth: _____
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SOCIAL HISTORY				
	YES	NO		
Do you use tobacco?			If yes, what form and how much?	
			If no, did you ever?	
			When did you quit?	
Exposure to second hand smoke?				
Do you drink alcohol?			If yes, how many drinks in 1 week?	
Do you drink caffeine?			If yes, what type and how much?	
Have you had a lot of sun damage?				
Do you use sunscreen?				

How would you rate your diet		Great		Average		Poor
Are you on a special diet?		Yes		No		
Do you use illicit drugs?		Yes		No		
Do you exercise?		Yes		No	If yes, how many times a week?	
Are you sexually active?		Yes		No		
Are you sexually active with:		Males		Females		Both
Do you use your cell phone while driving? (texting, talking, etc)		Yes		No		
Is there anything else you would like your doctor to know about you?		Yes		No		
If yes, please explain:						
Do you have cultural preferences or needs you would like the office to be aware of:						
How would you rate your dental health?		Great		Average		Poor

OTHER PROVIDERS OF CARE		
Provider's Name	**Reason for Seeing / Specialty**	**Date of Last Visit**

Name: _____ Date of Birth: _____
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CURRENT MEDICATIONS AND SUPPLEMENTS
(Prescription or Over-The-Counter)

Name of Medication	Dose/Frequency	Prescribing Physician (if not PCP)	Reason for Taking

ALLERGIES

Allergen	Describe Reaction	Medication Taken	Date of last occurrence

ADDITIONAL NOTES