Reid Health Physician Associates

SELF DIRECTED MEDICAL HISTORY

Today's Date:

PATIENT NAME		**DOB**
PRIMARY CARE PHYSICIAN	**WERE YOU REFERRED?** ☐ No ☐ Yes – By Whom	

Preferred Primary Pharmacy:

Pharmacy Name	**Address**	**Phone**

Have You Had Any of These Problems In the Last Six (6) Months? (Check all that apply.)

CONSTITUTIONAL

Chills?	☐ No	☐ Yes
Fatigue?	☐ No	☐ Yes
Fever?	☐ No	☐ Yes
Night Sweats?	☐ No	☐ Yes
Weakness?	☐ No	☐ Yes
Weight Gain?	☐ No	☐ Yes
Weight Loss?	☐ No	☐ Yes

EAR, NOSE, THROAT

Visual Changes?	☐ No	☐ Yes
Eye Discharge?	☐ No	☐ Yes
Eye Pain?	☐ No	☐ Yes
Difficulty Swallowing?	☐ No	☐ Yes
Hoarseness?	☐ No	☐ Yes
Nasal Congestion?	☐ No	☐ Yes
Nasal Drainage?	☐ No	☐ Yes
Facial Pain?	☐ No	☐ Yes
Hearing Loss?	☐ No	☐ Yes
Ringing in Ears?	☐ No	☐ Yes
Ear Discharge?	☐ No	☐ Yes
Ear Pain?	☐ No	☐ Yes
Vertigo/Dizziness?	☐ No	☐ Yes

RESPIRATORY

Cough?	☐ No	☐ Yes
Shortness of Breath?	☐ No	☐ Yes
Wheezing?	☐ No	☐ Yes
Pleurisy?	☐ No	☐ Yes
Tuberculosis (TB)?	☐ No	☐ Yes
Recent Infections?	☐ No	☐ Yes

CARDIOVASCULAR

Chest Pain?	☐ No	☐ Yes
Heart Murmur?	☐ No	☐ Yes
Leg Swelling?	☐ No	☐ Yes
Syncope (Fainting)?	☐ No	☐ Yes
Irregular Heartbeat/Palpitations?	☐ No	☐ Yes
Vertigo?	☐ No	☐ Yes
High Blood Pressure?	☐ No	☐ Yes
Varicose Veins?	☐ No	☐ Yes

GASTROINTESTINAL

Abdominal Pain?	☐ No	☐ Yes
Constipation?	☐ No	☐ Yes
Diarrhea?	☐ No	☐ Yes
Heartburn?	☐ No	☐ Yes
Nausea?	☐ No	☐ Yes
Vomiting?	☐ No	☐ Yes
Change in Stools?	☐ No	☐ Yes
Blood in Stools?	☐ No	☐ Yes
Loss of Appetite?	☐ No	☐ Yes
Excessive Thirst?	☐ No	☐ Yes

GENITOURINARY

Painful Urination?	☐ No	☐ Yes
Frequent Urination?	☐ No	☐ Yes
Blood in Urine?	☐ No	☐ Yes
Urge Incontinence?	☐ No	☐ Yes
Urinary Incontinence?	☐ No	☐ Yes
Urinary Retention?	☐ No	☐ Yes
Penile Discharge?	☐ No	☐ Yes

METABOLIC/ENDOCRINE

Cold Intolerant?	☐ No	☐ Yes
Hair Loss?	☐ No	☐ Yes
Heat Intolerant?	☐ No	☐ Yes

NEUROLOGICAL

Headache?	☐ No	☐ Yes
Difficulty Walking?	☐ No	☐ Yes
Dizziness?	☐ No	☐ Yes
Poor Coordination?	☐ No	☐ Yes
Memory Loss?	☐ No	☐ Yes
Muscle Weakness?	☐ No	☐ Yes
Numbness/Tingling?	☐ No	☐ Yes
Seizures?	☐ No	☐ Yes
Tremors?	☐ No	☐ Yes

PSYCHIATRIC

Anxiety?	☐ No	☐ Yes
Depression?	☐ No	☐ Yes
Insomnia?	☐ No	☐ Yes

INTEGUMENTARY

Brittle Hair / Nails?	☐ No	☐ Yes
Hair Loss?	☐ No	☐ Yes
Hair Growth?	☐ No	☐ Yes
Contact Allergy?	☐ No	☐ Yes
Rash?	☐ No	☐ Yes
Skin Infection?	☐ No	☐ Yes
Skin Lesion?	☐ No	☐ Yes
Mole Changes?	☐ No	☐ Yes

MUSCULOSKELETAL

Back Pain?	☐ No	☐ Yes
Joint Pain?	☐ No	☐ Yes
Joint Swelling?	☐ No	☐ Yes
Muscle Weakness?	☐ No	☐ Yes
Neck Pain?	☐ No	☐ Yes

HEMATOLOGIC

Easy Bleeding?	☐ No	☐ Yes
Easy Bruising?	☐ No	☐ Yes

IMMUNOLOGICAL

Asthma?	☐ No	☐ Yes
Bee Sting Allergy?	☐ No	☐ Yes
Contact Dermatitis?	☐ No	☐ Yes
Environmental	☐ No	☐ Yes
Allergies?	☐ No	☐ Yes

GYNECOLOGICAL

Number of Pregnancies	______
Age of First Pregnancy	______
Number of Live Births	______
Miscarriages / Abortions	______
Date of Last Period	______
Age of First Period	
Date of Last Pap	______
Last Normal Pap	______
Last Abnormal Pap	______

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Food Allergies? □ No □ Yes
Seasonal Allergies?

PATIENT NAME	**DOB**

MEDICAL HISTORY: Have you **ever** had or do you **now** have any of the following? □ **None / Healthy**

□ Alzheimer's Disease	□ DVT/Blood Clot	□ Hypertension	□ Renal Disease
□ Anemia	□ Deg Joint Disease	□ Inflammatory Bowel (IBS)	□ Scoliosis
□ Angina	□ Depression	□ Kidney Stones	□ Seizure Disorder
□ Arthritis	□ Diabetes: Type ____	□ Lyme Disease	□ Sleep Apnea
□ Asthma	□ Drug Abuse	□ Myocardial Infarction	□ Spinal Stenosis
□ Cancer ______________	□ Elevated Lipids	□ Obesity	□ Spondyloarthopathy
□ Congestive Heart Failure	□ Fibromyalgia	□ Osteoporosis	□ Stroke
□ COPD/Emphysema	□ Gout	□ Parkinson Disease	□ Systemic Lupus
□ Coronary Artery Disease	□ Headache/Migraine	□ Peptic Ulcer Disease	□ Thyroid Disease
□ Crohn's Disease	□ Hepatitis: __________	□ Psoriasis	□ Valvular Disease

Other:

SURGICAL HISTORY (Please check the types of surgery you have had and write the approximate year the surgery was performed.) □ **None** **Side = R- Right L- Left B- Both**

	SURGERY	YEAR			SURGERY	YEAR
□	Angioplasty			□	Hysterectomy	
□	Appendectomy			□	Knee Surgery – **Side**	
□	Back or Neck Surgery			□	Mastectomy / Breast – **Side**___	
□	Carotid Artery Surgery			□	Neurosurgery	
□	Carpal Tunnel Surgery – **Side**___			□	Prostate / Bladder	
□	Chest / Lung Surgery			□	Sinus Surgery	
□	Coronary Bypass Surgery			□	Stomach Surgery	
□	Ear Surgery – **Side**___			□	Thyroid Surgery	
□	Gallbladder Surgery			□	Tonsillectomy	
□	Hernia Repair			□	Trauma Related Surgery	
□	Hip Surgery – **Side**___					

	OTHER SURGERY:	YEAR
□		
□		

MEDICATIONS (Please list your current medications.) □ **None**

ALLERGIES TO MEDICATIONS / OTHER □ **None Known**

□ Aspirin □ Penicillin □ Latex □ Allergy to Metals

□ Codeine □ Sulfa □ Other

Allergic Reaction:

FAMILY HISTORY □ **None**

	Family Member?
□ Cancer	
□ Gout	
□ Kidney Disease	
□ Arthritis	
□ Diabetes	

Social History

Tobacco Use? □ Never □ Former □ Current
Tobacco Type? Usage per Day?
Ever Tried to Quit? Method?

Alcohol? □ None □ Socially □ Rarely □ Occasionally

☐ Heart Disease	
☐ Liver Disease	
☐ Osteoporosis	

☐ Yearly ☐ Weekly ☐ Daily
Caffeine Intake? ☐ Yes ☐ No Per Day? Type?
☐ Right Handed ☐ Left Handed ☐ Ambidextrous

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PATIENT NAME	**DOB**

Tattoos: ☐ Yes ☐ No If you marked yes, would you be interested in tattoo removal? ☐ Yes or ☐ No

PREVENTIVE TESTS / SERVICES (Please indicate more recent date and testing location.)

Preventive Test / Services	Year / Testing Location	Preventive Test / Services	Year / Testing Location	Preventive Test / Services	Year / Testing Location
Mammogram		Flexible Sigmoidoscopy		Bone Density Test	
Pap Smear		TB Test		Cardiac Angiogram	
Breast Exam		Colonoscopy		Stress Test	
Chest X-ray		Flu Vaccine		Prostate Cancer Test	
EKG		Pneumonia Vaccine		Eye Exam	
Rectal Exam		Tetanus Vaccine		Date of Last Physical Examination	
Colon Cancer / Stool Guaiac		Hepatitis Vaccine			

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS ACCURATE.

Patient / Legal Guardian Signature Date

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