Banner Medical Clinic
Berthoud

PATIENT MEDICAL HISTORY

Please take a moment to complete the following information ***as accurately as possible.*** *This information will be kept confidential and will help your physician with diagnosis and treatment.*

PAST MEDICAL HISTORY

SURGERIES	**DATE**		**DATE**
OTHER HOSPITALIZATIONS	**DATE**		**DATE**
OTHER ILLNESS/INJURIES (ex. diabetes, high BP, broken bones, thyroid disorders)	**DATE**		**DATE**

MEDICATIONS *(Include Aspirin, Tylenol, Birth Control Pills, Vitamins, Laxatives, etc.)*

NAME OF MEDICATION	**DOSAGE** *(50 mg, 5 gr, 2 tsp, etc)*	**FREQUENCY**

PATIENT'S NAME: _____ **DATE:** _____

ALLERGIES/ADVERSE REACTIONS (*to medications, injections, etc.*)

Name of Medication	Describe Reaction	Date

IMMUNIZATIONS:

Have you had a pneumonia (Pneumovax) vaccine?	Yes	No	If yes, when?
Do you take yearly influenza vaccines?	Yes	No	
When was your last tetanus vaccination?			

LIFESTYLES & HABITS:

TOBACCO:				
Have you ever smoked the following?	Cigarettes	Cigar	Pipe	None
If yes, how many cigarettes/cigars/pipe fulls per day?				
How many years have you or did you smoke?				
If you smoked and have quit, when did you quit smoking?				

ALCOHOL:				
Do you ever drink alcoholic beverages?	Never	Rarely	Occasionally	Daily
Approximate amount consumed? (*Example: 3 drinks per week*)				

COFFEE/TEA/SOFT DRINKS
How many cups of coffee do you drink per day, on the average?
How many cups or glasses of tea do you drink per day, on the average?
Is the coffee or tea decaffeinated?
How many soft drinks do you drink per day?

RECREATIONAL DRUG USE:				
Have you ever used recreational drugs such as marijuana, cocaine, etc.?	Yes		No	
If yes, which drugs?		When?		
Have you ever injected drugs into your veins?	Yes		No	

DIETARY HABITS:	

EXERCISE HABITS:	

HOBBIES:	

FAMILY HISTORY:

Relationship	Name	Sex	If Living		If Deceased	
			Age	Health	Age @ Death	Cause of Death

✓ Yes if any *blood relative* has, or has had, any of the following. List their relationship to you.

ILLNESS	YES	RELATIONSHIP		ILLNESS	YES	RELATIONSHIP
Hay Fever				**Diabetes**		
Asthma				**Thyroid Disorders**		
Emphysema				**Arthritis**		
High Blood Pressure				**Migraine Headaches**		
Stroke				**Epilepsy**		
Bleeding Tendency				**Alzheimer's Disease**		
Blood Disorders				**Mental Illness**		
Heart Failure				**Depression**		
Heart Attack				**Suicide**		
Colitis				**Cancer**		
Kidney Disease				What type of cancer?		

WORK/TRAVEL HISTORY:

What are/were your occupation(s)?			
Are you retired?	Yes	No	If yes, when did you retire?
Did you serve in the military?	Yes	No	
Where were you stationed (if applicable)?			
List all countries, outside of the U.S., to which you have traveled in the past five years:			
List any unusual exposures that you have had to fumes, chemicals, etc.:			

REVIEW OF SYSTEMS: (PLEASE ✓ APPROPRIATE ANSWERS)

YES	NO	GENERAL
		Do you usually feel tired or worn out?
		Have you recently noticed that heat or warm weather bothers you?
		Have you experienced any unusual weight gain or loss in the past six months?
		Have you had unexplained fever?
		Do you experience night sweats?
		Have you ever had a blood transfusion? If yes, when?
YES	**NO**	**SKIN**
		Have you noticed any skin rashes?
		Have you noticed any growth on your skin that bothers you?
		Have you noticed any sores or wounds that do not heal?
		Have you noticed any loss of hair in large amounts?
		Have you noticed any rash with sunlight exposure?
		Have you noticed tendency for your fingers to turn white with cold exposure?
YES	**NO**	**EYES**
		Have you had glaucoma?
		Have you had blurry vision?
		Have you had dryness of your eyes?
		Have you had persistent redness in your eyes?
YES	**NO**	**EARS, NOSE, THROAT**
		Do you have any trouble hearing?
		Do you have ringing or buzzing in your ears?
		Do you have any unusual dryness of your mouth?
		Do you have drainage down the back of your throat?
		Do you have frequent or severe nosebleeds?
		Do you have persistent hoarseness?
		Do you have frequent sinus infections?
		Do you have frequent colored nasal discharge?
		Do you have hay fever?
YES	**NO**	**RESPIRATORY**
		Do you have frequent chest colds?
		Do you have a constant or bothersome cough?
		Have you coughed-up blood?
		Do you have sputum or phlegm between colds?
		Do you have difficulty breathing?
		Have you noticed any wheezing or whistling in your chest?
YES	**NO**	**CARDIOVASCULAR**
		Do you have pain, tightness or pressure in your chest, throat or arms?
		If yes, is it when walking fast, working hard or when excited?
		Have you ever been told that your electrocardiogram was abnormal?
		Do you have swelling of your feet or ankles?
		Does your heart ever beat fast or irregularly?
		Do you have pain in the calf muscles when you walk?
		Do you ever awaken at night with severe difficulty breathing?

YES	NO	GASTROINTESTINAL	
		Have you recently had any change in your eating habits?	
		Are there any foods that cause you to have an upset stomach, pain, nausea, etc.?	
		Have you recently noted any trouble swallowing?	
		Do you have a lot of indigestion or heartburn?	
		Have you ever vomited blood?	
		Are you bothered with constipation?	
		Do you have frequent loose stools or diarrhea?	
		Do you have a poor appetite?	
		Have you ever passed blood from your rectum?	
		Have you ever had black or tarry stools?	
		Have you noticed any recent changes in your bowel movements?	
		Do you take laxatives regularly?	
		Do you have frequent nausea and/or vomiting?	
		Have you ever had an ulcer?	
		Have you ever had a sigmoidoscopy?	If yes, when?
		Have you ever had colon polyps?	
YES	**NO**	**GENITOURINARY**	
		Do you have burning or pain when you urinate?	
		Do you have to urinate frequently?	
		Do you have trouble urinating?	
		Do you have to get up at night to urinate?	
		Do you have trouble with losing urine when you cough or sneeze?	
		Have you ever passed blood in your urine?	
		Do you have anything wrong with your sexual organs?	
		Do you have anything wrong with sexual function?	
		When was your last prostate exam? (men only)	
YES	**NO**	**MUSCULOSKELETAL**	
		Do you have persistent back stiffness or pain?	
		Do you have muscle weakness?	
		Do you experience swelling in your joints?	
		Do you have joint pain or stiffness?	
YES	**NO**	**CENTRAL NERVOUS SYSTEM**	
		Do you have frequent or severe headaches?	
		Do you often have spells of dizziness, faintness or lightheadedness?	
		Do you ever have trouble remembering recent events?	
		Have you ever seen double?	
		Have you ever had convulsions or fits?	
		Do you have numbness or tingling in your hands, arms or legs?	
		Do you consider yourself a nervous person?	
		Do you cry a lot for no apparent reason?	
		Have you ever had an urge to commit suicide?	
		Have you ever had a nervous breakdown?	
		Do you feel depressed a lot of the time?	
		Do you have any significant problems with sleep?	

YES	NO	INFECTIOUS DISEASES
		Have you ever tested positive for Tuberculosis?
		Have you ever tested positive for HIV (AIDS virus)?
YES	**NO**	**WOMEN ONLY**
		Are your menstrual periods irregular?
		Have you had any lumps in your breasts?
		Have you had any discharge from your nipples?
		Are you using any birth control measures? If yes, what?
		Have you ever had a miscarriage, abortion or stillborn?
		When was your last menstrual period?
		When was your last mammogram?
		When was your last Pap smear?
		How many times have you been pregnant?

Thank You!