PARKRIDGE MEDICAL GROUP **Medical History**

Name:_____DOB:_____Age:_____

PERSONAL HISTORY ***(Please check past or present history of the following conditions)***

Past	Present	Condition	Past	Present	Condition
[ ]	[ ]	AIDS/HIV	[ ]	[ ]	Heart Murmur
[ ]	[ ]	Alcohol/Drug Problems	[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Anemia/Low blood counts	[ ]	[ ]	Hepatitis
[ ]	[ ]	Asthma	[ ]	[ ]	Hiatal Hernia
[ ]	[ ]	Blood clots in legs	[ ]	[ ]	Inguinal Hernia
[ ]	[ ]	Cancer (type:_____)	[ ]	[ ]	High Blood Pressure
[ ]	[ ]	Cataracts	[ ]	[ ]	High Cholesterol
[ ]	[ ]	COPD/Emphysema	[ ]	[ ]	Infertility
[ ]	[ ]	Depression/Anxiety	[ ]	[ ]	Kidney/Bladder problems
[ ]	[ ]	Diabetes (sugar)	[ ]	[ ]	Liver disease/Jaundice/Hepatitis
[ ]	[ ]	Easy Bleeding	[ ]	[ ]	Osteoarthritis
[ ]	[ ]	Eating Disorder (anorexia/bulimia)	[ ]	[ ]	Pneumonia
[ ]	[ ]	Eczema	[ ]	[ ]	Rheumatoid Arthritis
[ ]	[ ]	Genital Herpes	[ ]	[ ]	Rheumatic Fever
[ ]	[ ]	Genital Infections (chlamydia/gonorrhea)	[ ]	[ ]	Seizures/Fits/Epilepsy
[ ]	[ ]	Genital warts/HPV	[ ]	[ ]	Serious Injury/Serious Accident
[ ]	[ ]	Glaucoma	[ ]	[ ]	Skin Cancer
[ ]	[ ]	Gout	[ ]	[ ]	Stomach Ulcer
[ ]	[ ]	Hay Fever/Pollen Allergy	[ ]	[ ]	Stroke
[ ]	[ ]	Headaches	[ ]	[ ]	Transfusion (year_____)
[ ]	[ ]	Hearing Loss	[ ]	[ ]	Tuberculosis (TB)
[ ]	[ ]	Heart Attack/Heart Disease	[ ]	[ ]	Other (specify _____)
[ ]	[ ]	Hypothyroid (Low thyroid)	[ ]	[ ]	Other (specify _____)

SURGERY/HOSPITALIZATION/ACCIDENTS/INJURY HISTORY ***list any surgeries/ hospitalizations/injuries and the year.***

Operations/Conditions Requiring Hospitalization/Accident/Injury	Year
_____	
_____	

Men Only ***(Please check any of the following symptoms that apply to you.)***

Past	Present	Condition	Past	Present	Condition
[ ]	[ ]	Loss of sexual function	[ ]	[ ]	Prostate trouble
[ ]	[ ]	Discharge from penis	[ ]	[ ]	Sexually transmitted disease
[ ]	[ ]	Lump in testicles	[ ]	[ ]	Surgery on private parts

Women Only ***(Please check any of the following symptoms that apply to you.)***

Past	Present	Condition	Past	Present	Condition
[ ]	[ ]	Bleeding between periods	[ ]	[ ]	Abnormal Pap Smear
[ ]	[ ]	Heavy Periods	[ ]	[ ]	Breast discharge
[ ]	[ ]	Extreme menstrual pain	[ ]	[ ]	Breast lump
[ ]	[ ]	Unusual vaginal discharge	[ ]	[ ]	Painful intercourse
[ ]	[ ]	Sexually transmitted disease	[ ]	[ ]	Hot flashes

Date of last menstrual period:	_____	# of times pregnant:	_____
Age at first period:	_____	# of children born alive:	_____
Length of periods:	_____	# of children still born:	_____
Number of days between periods:	_____	# of miscarriages:	_____
Age when periods stopped:	_____	# of Caesarean sections:	_____
		Complications of pregnancy:	_____

Date of last Pap Smear:	_____		Date of last mammogram:	_____
Was it normal?	Yes____	No____	Was it normal?	Yes____ No_____
Date of last bone density:_____	_____		Are you sexually active?	Yes____ No_____
Was it normal?	Yes____	No____	Do you use birth control?	Yes____ No_____
			If yes, what type?	

ALLERGIES ***(Please list any drug allergies and the type of reaction you experience with each drug)***

Drug \Reaction
_____ _____

REVIEW OF SYMPTOMS (***Please check any of the following symptoms that apply to you).***

Past	Present	Symptom	Past	Present	Symptom
[ ]	[ ]	Weight change (unexpected)	[ ]	[ ]	Trouble swallowing
[ ]	[ ]	Fever	[ ]	[ ]	Heartburn
[ ]	[ ]	Chills	[ ]	[ ]	Constipation
[ ]	[ ]	Fatigue	[ ]	[ ]	Diarrhea
[ ]	[ ]	Night Sweats	[ ]	[ ]	Blood in stool
[ ]	[ ]	Trouble sleeping	[ ]	[ ]	Black, tarry stool
[ ]	[ ]	Appetite change	[ ]	[ ]	Pencil-thin stool
[ ]	[ ]	Headache	[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Visual change	[ ]	[ ]	Jaundice
[ ]	[ ]	Hearing loss	[ ]	[ ]	Nausea/Vomiting
[ ]	[ ]	Earache	[ ]	[ ]	Stomach pain which:
[ ]	[ ]	Ringing in ears	[ ]	[ ]	Occurs after a meal
[ ]	[ ]	Nosebleeds	[ ]	[ ]	Occurs with eating greasy, fried food
[ ]	[ ]	Sinus problems	[ ]	[ ]	Awakens you at night
[ ]	[ ]	Bleeding gums	[ ]	[ ]	Is relieved by antacids
[ ]	[ ]	Hoarseness	[ ]	[ ]	Seasonal/Environmental allergies
[ ]	[ ]	Sore throat	[ ]	[ ]	Red, itchy eyes
[ ]	[ ]	Shortness of breath:	[ ]	[ ]	Easy bruising
[ ]	[ ]	When doing usual work	[ ]	[ ]	Rash
[ ]	[ ]	When climbing a flight of stairs	[ ]	[ ]	Change in moles
[ ]	[ ]	Which awakens you at night	[ ]	[ ]	Itchy skin
[ ]	[ ]	Cough	[ ]	[ ]	Burning when urinating
[ ]	[ ]	Coughing up blood	[ ]	[ ]	Blood in urine
[ ]	[ ]	Wheezing	[ ]	[ ]	Frequent urination
[ ]	[ ]	Chest pain or tightness:	[ ]	[ ]	Trouble holding urine
[ ]	[ ]	When walking fast or up hill	[ ]	[ ]	Frequent nighttime urination
[ ]	[ ]	After a heavy meal	[ ]	[ ]	Muscle pain
[ ]	[ ]	When upset or excited	[ ]	[ ]	Joint pain
[ ]	[ ]	That radiates down your arm	[ ]	[ ]	Numbness
[ ]	[ ]	That disappears when you rest	[ ]	[ ]	Weakness
[ ]	[ ]	Irregular heartbeat	[ ]	[ ]	Seizures
[ ]	[ ]	Swelling of ankles	[ ]	[ ]	Fainting
[ ]	[ ]	Anxiety	[ ]	[ ]	Depression
[ ]	[ ]	Stress			

IMMUNIZATIONS: Tetanus Booster:_____ **Last pneumonia vaccine:**_____ **Last flu vaccine:**_____

PERSONAL HABITS

Do you regularly drink alcohol?	Yes	No	If yes, what amount?_____
Do you drink >4 cups of caffeinated beverages per day?	Yes	No	If yes, what amount?_____
Do you smoke?	Yes	No	If yes, how many packs per day?_____
			If yes, how many years?_____
Are you a former smoker?	Yes	No	If yes, how many packs per day?_____
			If yes, how many years?_____
Have you ever used street drugs?	Yes	No	If yes, what type?_____
Are you currently using street drugs?	Yes	No	If yes, what type?_____

FAMILY HISTORY

Relative	Age	If deceased, age of death	Medical Problems/Cause of death

MEDICATIONS ***Please list the medications, dosages, and frequencies that you currently use. Please include over-the-counter and herbal medications. If you already have a list that you would like us to copy, let the receptionist know and write "see attached sheet" below.***

Medication	Dosage	Frequency

_____ _____

Patient Signature **Date**

_____ _____

Physician Signature **Date**

Review Date:_____**Review Date:**_____**Reveiw Date:**_____