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: _____
Age at first period: _____
Length of periods: _____
Number of days between periods: _____
Age when periods stopped: _____

# of times pregnant: _____
# of children born alive: _____
# of children still born: _____
# of miscarriages: _____
# of Caesarean sections: _____
Complications of pregnancy: _____

Date of last Pap Smear: _____
Was it normal? Yes____ No____
Date of last bone density:_____
Was it normal? Yes____ No____

Date of last mammogram: _____
Was it normal? Yes____ No____

Are you sexually active? 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:**_____