# COMPREHENSIVE MEDICAL HISTORY

Patient: _____ DOB: _____ Date: _____ File #: _____
Last, First MM/DD/YYYY MM/DD/YYYY

**NAME OF GENERAL PRACTITIONER:** _____

**DATE OF LAST PHYSICIAL EXAMINATION:** _____

**INSTRUCTIONS FOR PAST MEDICAL-SYSTEMS REVIEW:** *Please check if you now, or ever, have experienced the following:*

***CONSTITUTIONAL***

1. ____Cancer
2. ____Allergies
3. ____Fever or chills
4. ____Weight loss or gain
5. ____Night sweats
6. ____Fatigue
7. ____Insomnia or changes in sleep
8. ____Other

***ENDOCRINE***

9. ____Diabetes
10. ____Thyroid disease
11. ____Intolerance to heat or cold
12. ____Increased thirst
13. ____Other

***EYE, EAR, NOSE, THROAT***

14. ____Glaucoma
15. ____Sinusitis
16. ____Poor vision
17. ____Pain in eye
18. ____Deafness/Difficulty hearing
19. ____Nosebleeds
20. ____Dental problems
21. ____Hoarseness
22. ____Other

***PULMONARY***

23. ____Asthma
24. ____COPD
25. ____Tuberculosis
26. ____Pneumonia
27. ____Difficulty breathing/ shortness of breath
28. ____Wheezing
29. ____Chronic cough or phlegm
30. ____Coughed up blood
31. ____Other

***GASTROINTESTINAL***

32. ____Appendicitis
33. ____Jaundice, Hepatitis, or Cirrhosis
34. ____Ulcer
35. ____Gallbladder disease
36. ____Colon polyps
37. ____Hemorrhoids
38. ____Poor appetite
39. ____Abdominal pain
40. ____Black or bloody stool
41. ____Frequent heartburn
42. ____Frequent bloating or gas
43. ____Frequent nausea or vomiting
44. ____Frequent diarrhea or constipation
45. ____Difficult swallowing
46. ____Other

***CARDIOVASCULAR***

47. ____Heart disease
48. ____High cholesterol or triglycerides
49. ____High blood pressure
50. ____Stroke
51. ____Rheumatic fever
52. ____Chest pain
53. ____Irregular/rapid heartbeat
54. ____Fainting/lightheadedness
55. ____Ankle swelling
56. ____Varicose veins
57. ____Other

***BLOOD/LYMPH***

58. ____Anemia
59. ____Bleeding disorder
60. ____Enlarged lymph nodes
61. ____Other

***SKIN***

62. ____Change in mole
63. ____Itching or rash
64. ____Other

Clinicians Comments:

# COMPREHENSIVE MEDICAL HISTORY

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Last, First MM/DD/YYYY MM/DD/YYYY

*GENITOURINARY*
65. ____Kidney disease or stones
66. ____Urinary infection
67. ____Sexually-transmitted disease
68. ____Sexual difficulties
69. ____Frequent or painful urination
70. ____Bloody or discolored urine
71. ____Incontinence
72. ____Other

*MALE SPECIFIC*
73. ____Prostate disease
74. ____Testicular pain or swelling
75. ____ Impotence/erectile dysfunction
76. ____Difficulty urinating
77. ____Other

*FEMALE SPECIFIC*
78. Date last period began:
_____
79. ____Live births
80. ____Miscarriage or abortion
81. ____Painful periods
82. ____Irregular or heavy periods
83. ____Breast lump or pain
84. ____Hot flashes
85. ____Other

*NEUROLOGIC/PSYCH*
86. ____Epilepsy or seizures
87. ____Headache
88. ____Psychiatric disorder
89. ____Weakness
90. ____Numbness/tingling
91. ____Dizziness
92. ____Tremor or twitching
93. ____Arm/leg pain
94. ____Depression or Anxiety
95. ____Other

*MUSCULOSKELETAL*
96. ____Fracture or dislocation
97. ____Arthritis
98. ____Scoliosis/ Spinal curvature
99. ____Neck or upper back pain
100. ____Lower back pain
101. ____Swollen/painful joint(s)
102. ____Other

*CHILDHOOD DISEASES*
103. ____Measles
104. ____Mumps
105. ____Chicken Pox
106. ____Other

*TRAUMA*
107. ____Motor vehicle accident
108. ____Other

HOSPITALIZATIONS and SURGERIES
(list dates and reasons)
109._____
110._____

SOCIAL HISTORY
111. ____Smoking/ tobacco use
112. ____Alcohol use
113. ____Recreational drug use
114. ____Sexually active with multiple partners
115. Are you married/partnered?
Yes No

Describe your exercise:
116._____
Describe your diet:
117:_____
What is your occupation?
118._____
Do you have a supportive home environment?
119._____

FAMILY HISTORY
120. ____Kidney disease
121. ____Heart disease or stroke
122. ____High blood pressure
123. ____Cancer
124. ____Thyroid disease
125. ____Diabetes
126. ____Neurological disease
127. ____Musculoskeletal disease
128. ____Psychiatric disease
129. ____Other

Clinician Comments:

☐ Reviewed Medication Sheet
☐ Completed APHR

_____
Clinician's Initials