Medical Diagnostic Associates, P.A.

Health History

(Confidential)

Name_____ **Birth date**_____ **Age**_____

Reason for Visit_____ **Date**_____

Symptoms: Check (√) symptoms you are currently experiencing

General:
- ☐ Chills
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Sweats
- ☐ Fatigue

Eyes:
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Tearing
- ☐ Red Eyes

Ears/ Nose/ Throat:
- ☐ Hoarseness
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Hearing Loss

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling of Legs

Respiratory:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing Blood

Gastrointestinal:
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel Changes
- ☐ Vomiting Blood
- ☐ Rectal Bleeding
- ☐ Bloating
- ☐ Hemorrhoids

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequent Urine
- ☐ Painful Urination
- ☐ Incontinence
- ☐ Urinating at Night

Mental Health:
- ☐ Loss of Sleep
- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Neurologic:
- ☐ Headaches
- ☐ Seizures
- ☐ Fainting
- ☐ Numbness
- ☐ Tremors

Musculoskeletal:
Pain in:
- ☐ Back
- ☐ Arms
- ☐ Legs
- ☐ Hands

Skin:
- ☐ Easy Bruising
- ☐ Itching
- ☐ Change in Moles
- ☐ Hives

Men Only:
- ☐ Breast Lump
- ☐ Erectile Difficulty
- ☐ Lump in Testicle
- ☐ Penis Discharge

Women Only:
- ☐ Abnormal Pap Smear
- ☐ Breast Lump
- ☐ Irregular Periods
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Number of pregnancies ____

Health Maintenance:
Date of last colonoscopy_____
Date of last Pap Smear_____
Date of last mammogram ____
Date of last PSA ____

CONDITIONS: Check (√) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Coronary Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Other

FAMILY HISTORY: Fill in information about your family						
Relation	**Age**	**State of Health**	**Cause of Death**		**Check if your blood relatives had: Disease**	**Relationship**
Father					Cancer	
Mother					Diabetes	
Brothers					High Blood Pressure	
					Heart Attacks	
					Strokes	
Sisters					Kidney Disease	
					Blood Clots	

HOSPITALIZATIONS/ SERIOUS ILLNESS		
Year	**Hospital**	**Reason for Hospitalization/ Illness**

Have you ever had a blood transfusion? ☐ Yes ☐ No Did you have a reaction_____
If Yes give approximate dates: _____

SOCIAL HISTORY					**Pregnancy History**		
	Current	Packs/drinks	Past	Packs/drink	Year of Birth	Sex	Complications
Tobacco							
Alcohol							
If you have quit smoking/ drinking how many years has it been? _____							
Occupation:_____					Have you had a miscarriage? If yes, how many_____		

I certify that he above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____