Annual Medical History

Date_____

Last Name_____ **First**_____ **MI** _____ **Date of Birth**_____

Allergies to Medications, X-Ray Dyes, or Other Substances:_____

Past Medical History: Have you been diagnosed with any new illnesses since we last saw you?

Operations/ Hospitalizations: Have you had any new operations or hospitalizations since we last saw you?

Immunization History: Are you due for any vaccines or booster shots?

Past Family History: Are there any new illnesses to add to your family history since the last time we saw you?

Review of Systems: Please circle if you are *currently* having any of the following:

General:

Weight Loss / Gain | Fever | Sleep Apnea | Loss of Appetite | Rash | Fatigue
Anxiety | Depression | Sleep Disturbance | Sleepiness During Daytime | Chills | Insomnia
Easy Bruising

Neurological:

Headaches | Numbness | Changes in Hearing | Changes in Vision | Last Eye Exam _____
Tingling | Dizziness | Lightheadedness | Changes in Gait

Cardiovascular:

Chest Pain | Palpitations | Heart Murmur: Do you take antibiotics before dental exams? Y N
Shortness of Breath | Swollen Ankles

Respiratory:

Wheezing | Shortness of Breath | Nasal Discharge? Y N If yes, color_____
Painful Breathing | Cough? Productive? Y N If yes, color_____

Gastrointestinal:

Indigestion | Rectal Bleeding | Black / Tarry Stools | Change in Bowel Habits | Heartburn | Reflux
Abdominal pain | Nausea | Vomiting | Hemorrhoids

Genitourinary:

Frequency | Burning with Urination | Getting Up During the Night to Urinate
Urgency | Changes in Sex Drive | Incontinence: stress or urge
Erectile Dysfunction

Musculoskeletal:

Bone Pain | Joint Pain | Muscle Aches

Notes:

Interval Gynecologic and Obstestric History

Are you using birth control? Y N If yes, which method?_____

Do you have any of the following:

Prolonged Bleeding | Abnormal Bleeding
Leakage of Urine | Pelvic pain | Abnormal Discharge | History of abnormal Pap Smear

When was your last: Pap Smear_____ Mammogram _____
Period_____ Breast Check_____ DEXA Scan (bone density)_____
Flexible Sigmoidoscope / Colonoscopy _____ Hemoccult _____

Lifestyle	Yes	No		Yes	No
Do you have a living will?	____	____	Do you smoke / chew tobacco?	____	____
Have you had blood tranfusions?	____	____	Do you drink alcoholic beverages?	____	____
Do you wish to be tested for AIDS?	____	____	What is your daily caffiene intake?_____		
Do you exercise regularly?	____	____	If yes, type & duration per week_____		

Reviewed by:_____ Date: _____