

Rockville Concierge Doctors
COMPLETE MEDICAL HISTORY FORM

DATE: _____

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

I. PAST MEDICAL HISTORY

A. Surgeries:

T & A (tonsils) Date: _____

Hysterectomy Date: _____

Appendectomy Date: _____ Ovaries removed? Yes No (circle)

Cholecystectomy Date: _____

Was hysterectomy done to treat a cancer? Yes No
(gallbladder)

Other surgeries and dates:

Biopsies done: what kind and dates:

B. Hospitalizations: (other than for surgeries)

Date: _____ Where: _____ Reason?

C. Injuries/Fractures (type, date and how injured):

D. Present Medications (prescription and over-the-counter):

Name	Dose	#Taken daily	Reason
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Herbs and Supplements:

E. Allergies: _____ or No known drug allergies

Medications: _____
What reaction: _____

Other Substances, Foods, etc:

F. Immunizations: Check Childhood Shots Given:

Tetanus Booster	Date: _____
Pneumovax (pneumonia vaccine)	Date: _____
Influenza (date of last shot)	Date: _____
Hepatitis B (series of 3 shots)	Date: _____
Shingles:	Date: _____
PPD	Date: _____
MCG :	Date: _____
Others:	_____

II. FAMILY HISTORY

Mother: Age (if living) _____ Age (at death) _____ Cause of death _____

List any medical problems she has had:

Father: Age (if living) _____ Age (at death) _____ Cause of death _____

List any medical problems he has had:

Brother (s) Ages and any medical problems he/they have had: _____

Sister (s) Ages and any medical problems she/they have had: _____

Any other blood relatives with:

Relationship _____
Diabetes _____
Heart attack _____
Stroke _____
Tuberculosis _____
Alzheimer's _____
Prostate cancer _____

Relationship _____
High blood pressure _____
Breast cancer _____
Colon cancer _____
High cholesterol _____
Melanoma (skin cancer) _____
Ovarian cancer _____

III. LIFESTYLE HISTORY

A. Marital Status:

Single Married Divorced
Significant Other (male) Significant other (female)

B. Have you ever been pregnant? Yes No N/A

If yes, how many pregnancies? _____ How many births / children? _____

C. Smoker (currently) ex-smoker non smoker chewing tobacco

If a smoker, number of packs (pipes, cigars) per day: _____
How long have you smoked? _____ If ex-smoker, when did you quit? _____

D. What do you usually drink? _____ how much? _____ how often? _____

Do not drink alcohol

E. Exercise:

Do you exercise regularly? _____ What activity? _____
How often? _____ How long is each session? _____

F. Diet -Check any foods you **avoid** in your diet:

salt sugar fats (oils) red meat eggs poultry wheat caffeine
 other

G. Usual number of meals per day: _____ Number of times per week you eat "fast foods" _____

H. Travel; Have you recently traveled outside the U.S.? _____

Where did you go? _____

I. Work :

Current Occupation: _____
Have you had any work related illnesses or injuries? _____

Injury/Illness _____ while employed as: _____

When _____

Do you have a history of exposure to toxic chemicals or substances? Yes No
 What Where

IV. REVIEW OF SYSTEMS

A. In the past, have you been diagnosed as having any of the following conditions?

Check and date:

<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Hardening of the arteries		<input type="checkbox"/> Phlebitis (blood clots)	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Migraine headaches	
<input type="checkbox"/> Stroke or "TIA"		<input type="checkbox"/> Cluster headaches	
<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Tension headaches	
<input type="checkbox"/> Angina		<input type="checkbox"/> Congestive heart failure	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Sinusitis		<input type="checkbox"/> Menieres Disease	
<input type="checkbox"/> Nasal polyps		<input type="checkbox"/> Allergic rhinitis	
<input type="checkbox"/> Tonsillitis		<input type="checkbox"/> Gum disease	
<input type="checkbox"/> Cervical (neck) strain		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lupus		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Chronic bronchitis	
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Fibrocystic breast disease		<input type="checkbox"/> Galactorrhea(breast discharge)	
<input type="checkbox"/> Hyperthyroidism (over-active thyroid)		<input type="checkbox"/> Hypothyroidism (low thyroid)	
REVIEW OF SYSTEMS (continued)			
<input type="checkbox"/> Pernicious anemia		<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Peptic ulcer (gastric or duodenal)		<input type="checkbox"/> Iron deficiency anemia	
<input type="checkbox"/> Gastritis/Esophagitis		<input type="checkbox"/> Giardia or other parasite	
<input type="checkbox"/> Intestinal polyps		<input type="checkbox"/> Malabsorption	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Diverticulitis	
<input type="checkbox"/> Irritable bowel (spastic colon)		<input type="checkbox"/> Chronic Fatigue syndrome	
<input type="checkbox"/> Reflux or GERD		<input type="checkbox"/> Enlarged prostate	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Crohn's colitis	
<input type="checkbox"/> Ulcerative colitis		<input type="checkbox"/> Prostatitis (prostate infection)	
<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Pelvic inflammatory disease	
<input type="checkbox"/> Epididymitis		<input type="checkbox"/> Uterine Fibroids	
<input type="checkbox"/> Dysmenorrhea		<input type="checkbox"/> Cystitis(bladder infection)	
<input type="checkbox"/> Vaginitis		<input type="checkbox"/> Hepatitis A, B or C	
<input type="checkbox"/> Pyelonephritis (kidney infection)		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Kidney Stone		<input type="checkbox"/> Gallstones	
<input type="checkbox"/> Hypoglycemia		<input type="checkbox"/> PMS or PMDD	
<input type="checkbox"/> Bulimia or Anorexia		<input type="checkbox"/> Depression	
<input type="checkbox"/> Any kind of Cancer		<input type="checkbox"/> Multiple sclerosis	
What kind?		<input type="checkbox"/> Neurologic disease	
<input type="checkbox"/> Abnormal x-ray findings:		<input type="checkbox"/> Panic attacks	
Describe		<input type="checkbox"/> High cholesterol or Triglycerides	
<input type="checkbox"/> Abnormal pap smear		<input type="checkbox"/> Sexual dysfunction	

B. Presently or in the recent past, have you had any of the following symptoms:

<input type="checkbox"/> Recurrent headaches		<input type="checkbox"/> Weight loss # of pounds lost	
<input type="checkbox"/> Fever (unexplained)		<input type="checkbox"/> Chills	
<input type="checkbox"/> Generalized fatigue		<input type="checkbox"/> Generalized weakness	
<input type="checkbox"/> Double vision		<input type="checkbox"/> Ringing in ears	
<input type="checkbox"/> Recurrent sinus infection		<input type="checkbox"/> Recurrent sore throats	
<input type="checkbox"/> Hoarseness		<input type="checkbox"/> Neck stiffness	
<input type="checkbox"/> Coughing up blood		<input type="checkbox"/> Chronic cough	
<input type="checkbox"/> Chest pressure or tightness on exertion		<input type="checkbox"/> Chest pressure or tightness at rest	
<input type="checkbox"/> Feeling dizzy or off-balance		<input type="checkbox"/> Pain in legs while walking	
<input type="checkbox"/> Change in appetite		<input type="checkbox"/> Abdominal burning pain	
<input type="checkbox"/> Nausea		<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Change in bowel habits		<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Painful urination		<input type="checkbox"/> Change in urinary habits	
<input type="checkbox"/> Breast Pain		<input type="checkbox"/> Weight gain # of pounds gained	
<input type="checkbox"/> Night Sweats		<input type="checkbox"/> Generalized body aches	
<input type="checkbox"/> Change in vision		<input type="checkbox"/> Change in hearing	
<input type="checkbox"/> Frequent nosebleeds		<input type="checkbox"/> Recurrent gum or tooth infections	
<input type="checkbox"/> Constant sinus drainage		<input type="checkbox"/> Trouble swallowing	
<input type="checkbox"/> Swollen glands		<input type="checkbox"/> Shortness of breath on exertion	
<input type="checkbox"/> Shortness of breath while laying down		<input type="checkbox"/> Coughing up phlegm in the morning	
<input type="checkbox"/> Feeling faint or almost passing out		<input type="checkbox"/> Swollen ankles or feet	
<input type="checkbox"/> Heartburn or indigestion		<input type="checkbox"/> Abdominal cramping pain	
<input type="checkbox"/> Vomiting		<input type="checkbox"/> Constipation	
<input type="checkbox"/> Blood in or on stool		<input type="checkbox"/> Frequent or urgent urination	
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Vaginal discharge or odor	
<input type="checkbox"/> Change in menstrual periods		<input type="checkbox"/> Change in sexual desire	
<input type="checkbox"/> Breast lump		<input type="checkbox"/> Nipple discharge	
<input type="checkbox"/> Testicular pain		<input type="checkbox"/> Skin rash	
<input type="checkbox"/> Easy bruising or bleeding		<input type="checkbox"/> Changes in hair	
B. Presently or in the recent past, have you had any of the following symptoms:			
<input type="checkbox"/> Trouble sleeping		<input type="checkbox"/> Depression	
<input type="checkbox"/> Muscle weakness or pain		<input type="checkbox"/> Tingling in hands or feet	
<input type="checkbox"/> Joint swelling		<input type="checkbox"/> Testicular swelling	
<input type="checkbox"/> Changes in skin or moles		<input type="checkbox"/> Lumps in neck, underarms or groin	
<input type="checkbox"/> Sensation of being too hot or too cold		<input type="checkbox"/> Nervousness, panic	
<input type="checkbox"/> Mood swings		<input type="checkbox"/> Numbness	
<input type="checkbox"/> Joint pains		<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Head injury and loss of consciousness		<input type="checkbox"/> Memory loss	

List any other problems not mentioned above:

V. HEALTH MAINTENANCE

A. Date of last physical / annual exam: _____

Examiner _____

B. Date of last Pap smear

C. Date of last Cholesterol level

D. Date of last EKG

E. Date of last Chest X-ray

F. Date of last Prostate exam

G. Date of last complete blood tests

H. Date of last Thyroid level

I. Date of last Sigmoidoscopy or Colonoscopy

J. Date of last Bone density test

K. Date of last mammogram

L. Do you use a seat belt in your car? _____

VI. CHIEF COMPLAINT: Please list below the main reason for your visit today and other specific concerns or problems you want the doctor to discuss with you. **Reason for visit:**
