

MEDICAL HISTORY CHECK-LIST

PREPARED FOR:	BY:	Date:
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Have you ever had:

- | | | | | | | | | | |
|-----------------------------|--------------------------|-----|--------------------------|----|---------------------|--------------------------|-----|--------------------------|----|
| Scarlet Fever | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Asthma | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Meningitis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Emphysema | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Infectious Mononucleosis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Arthritis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Tuberculosis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Back trouble | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Exposure to TB | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | High blood pressure | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Malaria | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Heart disease | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Bronchitis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Anemia | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Pneumonia | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Bleeding tendency | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Pleurisy | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Nose bleeds | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Hepatitis (yellow jaundice) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Ulcer | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Bladder infections | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Cancer | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Rheumatic fever | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Hemorrhoids | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Kidney disease | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Blood transfusion | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Hives | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Diabetes | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Hay fever/sinusitis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | | | | | |

FAMILY HISTORY

Has any blood relative had any of the following:

- | | | | | | | | | | |
|-------------------------|--------------------------|-----|--------------------------|----|---------------------|--------------------------|-----|--------------------------|----|
| Anemia | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Migraine headaches | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Leukemia | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Diabetes | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Repeated infections | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Gout | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Crippling arthritis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Obesity | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Chronic lung disease | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Thyroid trouble | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| High blood pressure | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Peptic ulcer | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Kidney disease | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Chronic diarrhea | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Asthma | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Cancer | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Severe allergies | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Suicide | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Mental illness | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Gallbladder Disease | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Convulsions or seizures | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Alcoholism | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

If yes, what relationship:

MEDICAL HISTORY CHECK-LIST

OPERATIONS

C Section	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tonsils	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Varicose Veins	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Gall Blander	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hemorrhoids	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Breast	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Uterus and/or Ovary	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Kidney Stones	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Prostate	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hernia	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

INJURIES

Head	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Broken bones	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Back	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Abdomen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO

ALLERGIES

Are you allergic to:

Foods	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cosmetics	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sulfa	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tetanus antitoxin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other drugs: please list:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

IMMUNIZATIONS

Tetanus shot	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Flu shot	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Polio oral	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Others(list)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

GENERAL

Have you had a lot of any of these symptoms now or in the last six

Tire easily weakness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sensitivity to heat	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Market weight change	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sensitivity to cold	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Night sweats	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hernia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Persistent fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

SKIN

Eruptions (rash)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Changes in hair	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Change in color	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Changes in nails	<input type="checkbox"/> YES	<input type="checkbox"/> NO

MEDICAL HISTORY CHECK-LIST

EYES

Trouble seeing Eye pain YES NO Double vision YES NO
Inflamed eyes YES NO Worn glasses YES NO

EARS

Loss of hearing YES NO Discharge YES NO
Ringing in ears YES NO

NOSE

Loss of smell YES NO Excess discharge YES NO
Frequent colds YES NO Nosebleeds YES NO
Obstruction YES NO

MOUTH

Sore gums YES NO Dental problems YES NO
Soreness of tongue YES NO

THROAT

Post nasal drainage YES NO Hoarseness YES NO
Soreness YES NO

BREASTS

Lumps YES NO
Discharge YES NO

CARDIO-RESPIRATORY SYSTEM

Cough persisting YES NO Difficult breathing lying down YES NO
Sputum (phlegm) YES NO Swelling of ankles YES NO
Bloody sputum YES NO Bluish fingers or lips YES NO
Wheezing YES NO High blood pressure YES NO
Chest pain or discomfort YES NO Palpitations YES NO
Pain on breathing YES NO Vein trouble YES NO
Shortness of breath YES NO Other YES NO

MEDICAL HISTORY CHECK-LIST

GASTRO-INTESTINAL

Symptoms now or in the last six months?

Change in appetite	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Vomiting	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Difficulty swallowing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Vomiting of blood	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heartburn	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rectal bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Abdominal distress	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tarry stools	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Belching or excess gas	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Abdominal enlargement	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Constipation	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Nausea	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hemorrhoids	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			Need for laxatives	<input type="checkbox"/> YES	<input type="checkbox"/> NO

GENITOURINARY SYSTEM

Increase in urination frequency (day)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Unable to hold urine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Increase in urination frequency (night)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pain or burning	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Feel need to urinate			Blood in urine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
without much urine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Lack of sex drive	<input type="checkbox"/> YES	<input type="checkbox"/> NO

ENDOCRINE

Thyroid trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cortisone treatment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Adrenal trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO

LOCOMOTOR

Muscle cramps	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Swollen joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Muscle weakness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stiffness	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pain in joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Deformity of joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO

NERVOUS SYSTEM

Headache	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Depression		
Dizziness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Change in sensation		
Fainting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Memory loss		
Convulsions or fits	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Poor coordination		
Nervousness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Weakness or paralysis of muscles		
Sleeplessness	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

OBSTETRICS-GYNECOLOGY

Started menstruating at age_____	Duration_____ days_____
Date of last period ___/___/___	Flow:___ light___normal___ heavy___
Interval between periods_____	Pain with periods: yes_____no_____
	Duration: _____days_____