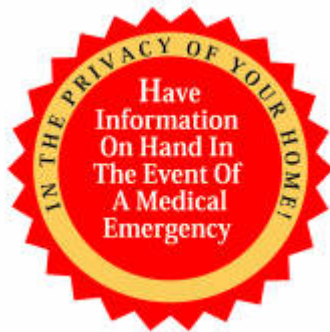




CareManager Home Medical History Check-List



A comprehensive medical history check-list to submit to new physicians or healthcare provider



CareManagerHome.com

Celebrating our 15th Year
Developed, Published - Distributed by

Planet
Media Group, LLC
Orlando, Florida

HealthHistory.com
(888) 669-9697



CareManagerPro.com

MEDICAL HISTORY CHECKLIST

**THIS DOCUMENT
PREPARED FOR:**

**THIS DOCUMENT
PREPARED BY: . .**

LAST UPDATE:

HAS THIS PERSON EVER HAD:

	YES	NO	???		YES	NO	???
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure To TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Yellow Jaundice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

FAMILY HISTORY

	YES	NO	???		YES	NO	???
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crippling Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

SURGERIES

	YES	NO	???		YES	NO	???
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C Section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall Baldder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (See Category Note)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uterus / Ovary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

MEDICAL HISTORY CHECKLIST

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INJURIES	YES	NO	???		YES	NO	???
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (See Category Note)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

ALLERGIES	YES	NO	???		YES	NO	???
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carrots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claritan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (see Category Note)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paint & Solvents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peanuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shell Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus Antitoxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

IMMUNIZATIONS	YES	NO	???		YES	NO	???
Cholera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ebola	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (see Category Note)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumoxas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus Shot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Typhus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
West Nile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

SYMPTOMS IN THE LAST 6 MONTHS:	YES	NO	???		YES	NO	???
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marked Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity To Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity To Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tire Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

SKIN	YES	NO	???		YES	NO	???
Change In Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes In Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes In Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eruptions (Rash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

EYES	YES	NO	???		YES	NO	???
Corrective Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

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EARS	YES	NO	???		YES	NO	???
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing In Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

NOSE	YES	NO	???		YES	NO	???
Excess Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss Of Smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

MOUTH	YES	NO	???		YES	NO	???
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

THROAT	YES	NO	???		YES	NO	???
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE:

BREASTS	YES	NO	???		YES	NO	???
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

CARDIO-RESPIRATORY SYSTEM	YES	NO	???		YES	NO	???
Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bluish Fingers Or Lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain Or Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing While Prone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (See Category Note)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain On Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness Of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sputum (Phlegm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling Of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vein Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

GASTRO-INTESTINAL	YES	NO	???		YES	NO	???
Abdominal Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching Or Excess Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change In Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

MEDICAL HISTORY CHECKLIST

**THIS DOCUMENT
PREPARED FOR:**

**THIS DOCUMENT
PREPARED BY: . .**

LAST UPDATE:

GENITOURINARY SYSTEM

YES NO ???

YES NO ???

- Blood In Urine
- Increase In Daily Urination
- Lack Of Sex Drive
- Unable To Hold Urine

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Burning During Urination
- Increase In Nightly Urination
- Pain During Urination
- Urge to Urinate W/Out Urine

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

ENDOCRINE

YES NO ???

YES NO ???

- Adrenal Problems
- Diabetes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Cortisone Treatment
- Thyroid Problems

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

LOCOMOTOR

YES NO ???

YES NO ???

- Deformity Of Joints
- Muscle Cramps
- Stiffness

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Joint Pain
- Muscle Weakness
- Swollen Joints

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

NERVOUS SYSTEM

YES NO ???

YES NO ???

- Change In Sensation
- Depression
- Fainting
- Memory Loss
- Paralysis Of Muscles
- Sleeplessness

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Convulsions Or Seizures
- Dizziness
- Headache
- Nervousness
- Poor Coordination
- Weakness Of Muscles

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: