

MEDICAL AND SURGICAL CLINICS OF SOUTHERN MARYLAND

Personal Health History

Name: _____ Sex: _____ Date: _____

Birth Date: _____ Race: _____ Occupation: _____

Marital Status: Single Divorced/Sep Widow(er) Religion: _____

Number of Children (if any) _____ Sex/Ages: _____

Current Weight: _____ Height: _____

Please check if you have any of the following medical illnesses and when you were diagnosed.

	Year Diagnosed		Year Diagnosed
Diabetes Mellitus (sugar)		Heart disease (any type)	
Hypertension (high blood pressure)		Gout (high uric acid)	
Hyperlipidemia (high blood cholesterol)		Arthritis	
Thyroid disease (goiter)		Other:	

Please list the medicines that you currently are taking, include the dose if known, how often you take them (include birth control pills and over the counter medicines, herbs or vitamins))

Name of Medicine	Dose	How often	Name of Medicine	Dose	How often

Are there medications that you are Allergic to or make you ill? No Yes If yes, please list the name of the drug and the type of reaction you get (Example Penicillin – rash)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Do you have an advanced directive (living will)? Yes No

Do you wear seat belts? Yes No If no, why not? _____

Do you smoke? Yes Never Quit (how long ago? _____) Cigarettes Cigars Pipe

Have you ever smoked: Estimate the number of total year(S) smoking _____ Average # of packs per day _____

Do you drink alcoholic beverages? Yes Never Quit (how long ago? _____)

Do you use any substances such as marijuana, cocaine, heroin? Yes Never Quit (when? _____)

If you ever used substances, how frequently? Daily Weekly Occasionally Type _____ Amount _____

Do you have regular exposure to chemicals or radiation? Yes No Type _____

When was your last complete physical exam? _____ Last chest x-ray? _____ Last EKG? _____

List any surgeries/hospitalization you have undergone and approximate year:

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Check any of these symptoms you have had recently

Headaches (frequent or severe)	Burning with urinating	Heartburn
Ear Infections	Dark or bloody urine	Chest pain or pressure
Sinus problems	Coughing	Abdominal pain
Soar throat	Coughing up blood	Weight loss
Blurry vision	Weakness or fatigue	Constipation
Nose bleeds	Bothered by hot or cold	Diarrhea
Facial Pain	Drinking more fluids	Black or bloody stool
Trouble swallowing	Pain in legs with walking	Nausea, vomiting
Vaginal discharge/burning	Pain/burning/numbness of feet	Change in bowel habits
Soars on genitals, STDs, VD	Short of breath with activity	Urinating more frequently
Boils	Shortness of breath at night	Urinating at night
Lumps	Night sweats	Dry skin
Dental Problems	Hearing difficulties	Skin rash
Frequent muscle cramps	Unexplained weakness	Palpitations
Fainting		

Family History

List ages and health (Good, Fair, Poor) of relatives listed below. If deceased, list age of death and cause if known.

Father _____ Mother _____

Brothers _____ Sisters _____

Does anyone in the family have any of the following diseases, please indicate who;

Diabetes _____ Hypertension _____

Heart Disease _____ Thyroid Disease _____

Stroke _____ Cancer _____

Psychiatric _____ Other _____

Women Only:

Age onset of menses (period) _____ Date of last period _____

Date of last Pap _____ Last Mammogram _____ History of abnormal pap Yes No

No. of pregnancies # live births _____ # miscarriages _____ # of Abortions _____

Hysterectomy? _____ If yes, when & what for? _____

If still menstruating, are your periods regular? _____ If yes, average # days between _____ # days flow _____

The history I have given in this form is true and accurate; the doctors shall rely upon it.

Signature: _____

Date: _____

Reviewed with patients	Date								
	Initials								