Southwest General Medical Group

Patient History

Name:_____ Age: _____ DOB: _____ Date: _____
Occupation: _____ Last Physical Exam date: _____
Previous Physician: _____

Below are a number of questions concerning possible present symptoms and / or past medical history. Please answer the questions as accurately as possible. This will enable us to become completely familiar with your medical history as well as enable us to expedite proper medical services to you. This is a confidential record of your medical history and will not be released to anyone without your prior consent.

List all past medical conditions:

_____
_____
_____
_____

Operations / Hospitalization	Yes	No	Date
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Uterus (women)			
Ovaries (women)			
Prostate (man)			
Joint Replacement			
Pregnancy / C-Section			
Other:			

Female Only Menstrual History:

Onset at age:_____
Days of flow: _____
Length of cycle: _____
Number of pregnancies: _____
Last mammogram (date): _____
Last Pap / Pelvic / Breast exam (date):_____

List below all medications you are presently taking
(including birth control and diet pills).

List all allergies to medications:

SOCIAL HISTORY

Do you:	Yes	No	Daily consumption
Use tobacco			packs
Drink coffee			cups
Alcohol			servings
Hard liquor / wine consumption			servings

Other information:
Have you received a blood or plasma transfusion ☐ Y ☐ N
Substance abuse: ☐ Y ☐ N

IMMUNIZATION ***(check those you have had and please note year)*:**

☐ Tetanus ☐ Pneumonia ☐ Hepatitis B
☐ Chicken Pox ☐ Childhood Immunization(s)
☐ Other:_____

FAMILY HISTORY

	Living			Health Problems	
	Age	Health			Age at death	Health Problems Cause of Death
		Good	Fair	Poor		
Father						
Mother						
Brother(s)						
Sister(s)						

Please ✓ box below and list blood relative next to illness:

☐ Anemia_____ ☐ Heart Disease_____
☐ Arthritis_____ ☐ High Blood Pressure_____
☐ Asthma_____ ☐ Stroke_____
☐ Cancers_____ ☐ Thyroid Disease_____
☐ Depression / Suicidal ☐ Tuberculosis_____
_____ ☐ Uncontrolled Bleeding_____
☐ Diabetes_____ ☐ Ulcer_____
☐ Epilepsy_____ ☐ Other: _____

Doctor's Use Only – Summary:

Continued on Reverse

Have you had problems with any of the following within the **PAST** year?

General
- ☐ Weight Loss or Gain
- ☐ Fever
- ☐ Trouble Sleeping
- ☐ Chronic Fatigue
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Abnormal Thirst

Eyes
- ☐ Itchy, Red eyes
- ☐ Vision Problems

Ears
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss

Nose
- ☐ Sinus Problems
- ☐ Nose Bleeds

Mouth
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Dental Problems

Lungs
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Blood Clot in Lungs
- ☐ Painful Breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Ankle or Hand Swelling

Gastrointestinal
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Blood Stools
- ☐ Nausea / Vomiting
- ☐ Hemorrhoids

Urinary
- ☐ Incomplete Urination
- ☐ Loss of Urine
- ☐ Painful Urination
- ☐ Bloody Urine

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Clot in Leg Vein

Neurologic
- ☐ Frequent / Severe Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble Walking
- ☐ Fainting Spells

Skin
- ☐ Acne
- ☐ Unwanted Hair Growth
- ☐ Unusual Lump or Growth
- ☐ Dry Skin

Emotional
- ☐ Excessive Worry
- ☐ Depression
- ☐ Frequent Crying
- ☐ Serious Thoughts of harming yourself or others

Menstrual Problems
- ☐ Cramps / Pain
- ☐ Heavy Bleeding
- ☐ Too Frequent Periods
- ☐ Bleeding Between Periods
- ☐ Missed a Period
- ☐ Other Period Issues

Pre-Menstrual Problems
- ☐ Bloating / Swelling
- ☐ Mood Changes
- ☐ Breast Changes
- ☐ Headaches
- ☐ Acne
- ☐ Other PMS Issues

Menopause Issues
- ☐ Hot Flashes
- ☐ Night Sweats

Breast Problems
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Other Breast Issues

Other Gynecologic Issues
- ☐ Vaginal Discharge
- ☐ Itching / Irritation
- ☐ Vulvar Pain
- ☐ Vulvar Lumps / Growth
- ☐ Vulvar Sores

Sexual Problems
- ☐ Painful Intercourse
- ☐ Bleeding after Intercourse
- ☐ Decreased Desire
- ☐ Orgasm Problems
- ☐ Dryness
- ☐ Possible Exposure to STD
- ☐ Other Sexual Issue

Would you like to discuss any of the following?
- ☐ Contraception
- ☐ Menopause Issues
- ☐ Pregnancy Issues
- ☐ Self Breast Exam
- ☐ Sexuality Issues
- ☐ STD's
- ☐ Other

Other (please explain):

Doctor's Use Only – Summary:

Continued from Front