PATIENT'S CHECK LIST FOR MEDICAL HISTORY

NAME: DATE:

PAST SURGERIES: None ☐ — or, list here any past surgeries with approximate age at which performed (include minor surgeries such as tonsilectomy, tumors, etc.)

ACCIDENTS: No injuries of consequence ☐ — or, list any serious type injuries, with approximate age.

PAST ILLNESSES: No serious past illnesses ☐ — or, list same with age:

List childhood diseases:

FAMILY HISTORY: If any of the following have run in your family, check appropriate square:

Allergies ☐; Cancer ☐; Tuberculosis ☐; Diabetes ☐; Heart Disease ☐; Strokes ☐

Place a check mark in the appropriate squares in the following lists of symptoms.
If you have had a symptom in the past and do not have it now, check square like this: ☑
If you are having the symptom at the present time, encircle the square like this: ☑

1. HEAD AND NECK

	Yes	No		Yes	No		Yes	No
Severe headaches?	☐	☐	Severe hearing loss?	☐	☐	Chronic nose obstruction?	☐	☐
Dizzy spells?	☐	☐	Ringing in ears?	☐	☐	Chronic sore tongue?	☐	☐
Failing vision?	☐	☐	Pain in ears?	☐	☐	Persistent sore gums?	☐	☐
Eye pain?	☐	☐	Discharge from ear?	☐	☐	Prolonged hoarseness?	☐	☐
Double vision?	☐	☐	Repeated nosebleeds?	☐	☐	Persistent neck rigidity?	☐	☐
See "floating lights"?	☐	☐	Toothache at present?	☐	☐	Swellings in neck?	☐	☐

2. HEART AND LUNGS

Chest pain on effort?	☐	☐	Sit up to breathe easy?	☐	☐	Have night sweats?	☐	☐
Skipping heart beats?	☐	☐	Have chronic cough?	☐	☐	Ankles swell?	☐	☐
Difficult breathing?	☐	☐	Spit up blood?	☐	☐	Any heart defects?	☐	☐

3. STOMACH AND INTESTINES

Chronic abdominal pain?	☐	☐	Vomit blood?	☐	☐	Any blood from rectum?	☐	☐
Persistent nausea?	☐	☐	Skin turn yellow?	☐	☐	Clay colored stools?	☐	☐
Heart burn?	☐	☐	Any chronic diarrhea?	☐	☐	Habitual constipation?	☐	☐
Appetite loss?	☐	☐	Any black tarry stools?	☐	☐	Have hemorrhoids?	☐	☐

4. URINARY TRACT — ETC.

						(For Women Only)		
Any excess urination?	☐	☐	Pain with urination?	☐	☐	Painful menstruation?	☐	☐
Any urinary shutdown?	☐	☐	Any leakage of urine?	☐	☐	Excess menstruation?	☐	☐
Scanty urination?	☐	☐	Passed any stones?	☐	☐	Bleed between periods?	☐	☐
Any blood in urine?	☐	☐	Any bedwetting?	☐	☐	Any missed periods?	☐	☐
Excess night urination?	☐	☐	Any retention of urine?	☐	☐	Number of pregnancies	.....	
						Number of living children	.....	

5. MUSCLES — JOINTS — NERVES

Any tingling sensations?	☐	☐	Any limited motions?	☐	☐	Speech disturbances?	☐	☐
Any numbness?	☐	☐	Any joint trouble?	☐	☐	Any seizures?	☐	☐
Disturbance in walking?	☐	☐	Nervous breakdown?	☐	☐	Any alcohol problem?	☐	☐
Any muscle jerking?	☐	☐	Any strokes?	☐	☐	Any drug problem?	☐	☐
Any paralysis?	☐	☐	Any memory loss?	☐	☐	Any mental problem?	☐	☐
Any shaking?	☐	☐	Personality changes?	☐	☐	Any varicose veins?	☐	☐

6. ALLERGIES

Any food allergy?	☐	☐	Inhalation allergy?	☐	☐	Adhesive tape allergy?	☐	☐
Any medication allergy?	☐	☐	Any contact allergy?	☐	☐	Subject to skin rash?	☐	☐

If there are any food or medication allergies, list here what they are:

LIST BELOW ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING.