

PATIENT MEDICAL HISTORY

Pt Initials: _____ Date: _____



SYSTEM	List Diagnosis or problem Include surgeries and hospital admissions with Date		
	YES	NO	
Kidneys, urinary system, prostate, bladder			
Leukemia, thin blood, blood problems			
Eyes, ears, nose or throat			
Heart, blood pressure high or low-			
Lungs, TB breathing problems			
Muscles or skeletal, broken bones or fractures			
Stomach, intestine or bowel problems			
Nerves, tingling in legs or arms, stroke			
Diabetes, or any gland problems			
Hepatitis			
Skin			
Liver, cirrhosis			
Hepatic			
HIV or Aids positive			
Allergies			
Other: _____ (specify)			
Other: _____ (specify)			
If female:			Last Period: _____ (If post Menopausal list year only)
Use of Tobacco:			#packs per day _____
Use of Alcohol:			Consumption Amount and Frequency: _____