RETURNING PATIENT MEDICAL HISTORY FORM

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WHY WALK-IN WHEN YOU CAN LOG-IN?

Full Name: _____ Date: _____

Birth Date: _____ Age _____

CHANGE IN MEDICATIONS FROM LAST VISIT

NEW MEDICATIONS	DISCONTINUED MEDS	SUPPLEMENTS

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date:	Facility/Provider:	Abnormal Result? Y N
Colonoscopy/Sigmoid	Date:	Facility/Provider:	Abnormal Result? Y N
Mammogram	Date:	Facility/Provider:	Abnormal Result? Y N
Pap Smear	Date:	Facility/Provider:	Abnormal Result? Y N
Bone Density	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	COVID vaccine:

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********** NOTE ANY CHANGES FROM LAST VISIT **********

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			

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WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: Age of Menopause:
Total Number of Pregnancies:	Number of Live Births: Number of Abortions (spontaneous or elective):
Pregnancy Complications:	

SURGERIES SINCE LAST VISIT:

TYPE *(specify left/right)*	**Date**	**Location/Facility**

HEALTH ISSUES

sexual activity	Sexually involved currently? Y N		
Sexual partner(s) is/are/have been: o Male	o Female		
Birth control method: None Condom IUD	Pill/Ring/Patch/Inj	Vasectomy	Abstinence
exercise	Do you exercise regularly?	Y N *(If you answered no, please move to Sleep)*	
sleep	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? o Good o Fair o Poor	Would you like advice on your diet? Y N	
Working smoke detector in home? Y N	If you have guns at home, are they locked up? Y N		
Is violence at home a concern for you? Y N	Please explain:		

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OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

********** REVIEW OF SYSTEMS- CHECK ALL THAT APPLY **********

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Racing Heart		Rash
	Sweating		**Gastrointestinal**		Wound
	Fatigue		Abdominal distention		**ALLERGY/IMMUNO**
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Rectal bleeding		Food allergies
	HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		**NEUROLOGICAL**
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches

	Ear pain		Vomiting		Light-headedness
	Facial swelling		**ENDOCRINE**		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Drinking a lot		Syncope
	Postnasal drip		Eating a lot		Tremors
	Runny Nose		Peeing a lot		Weakness
	Sinus pressure		**Genitourinary**		**HEMATOLOGIC**
	Sneezing		Difficulty urinating		Swollen Lymph nodes
	Sore throat		Dysuria		Bruises/bleeds easily
	Ringing in ears		Urine leakage		**PSYCHIATRIC**
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Blood in urine		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Sensitive to light		Scrotal swelling		Nervous/anxious
	Visual changes		Testicular pain		Self-injury
	RESPIRATORY		Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness		**MUSCULAR**		
	Choking		Joint aches		
	Cough		Back pain		
	Shortness of breath		Problems walking		
	Stridor		Joint swelling		
	Wheezing		Muscle pains		
			Neck pain		
			Neck stiffness		