Providing information about your personal and family medical history is one of the best ways to help your physician learn a great deal about your health in a short period of time. The questions in the Medical History Worksheet are designed to help you remember and communicate important details of your past and current health history. Complete as much of the worksheet as possible, answering as many of the questions as you can.

Name___________________________________________________ Date of Birth_________________________

Height__________________ Weight_______________ lbs Right-handed Left-handed

Please describe the problem you are experiencing:

_____________________________________________________________________________________________

How long have you been having this problem? ____________________________________

How often does this problem occur? _____________________________________________

How severe is the problem Very Severe Moderately Severe Mild

Are there things that make this problem worse?

_____________________________________________________________________________________________

Are there things that make this problem better?

_____________________________________________________________________________________________

What activities can you no longer do because of this problem?

_____________________________________________________________________________________________

Do you experience this problem with movement? Yes No

Do you experience this problem at rest? Yes No

**Medical History**

Prior Medical Problems (Include any Neurological and /or Orthopaedic related problems):

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Surgical History (list all operations and dates):

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Previous Hospitalizations other than Surgery (Include reason for hospitalization and dates):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Medications (List all present medications with dosages - include over–the-counter vitamins, Tylenol, etc.):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Allergic History to Medications (List medication and specific allergy and/or reaction):

______________________________________________________________________________

______________________________________________________________________________

**Family History** (list age and medical problems of parents, siblings, and children – if any deaths have occurred in the family please list age and cause of death):

Mother: ______________________________________________________________________________

Father: ______________________________________________________________________________

Brother(s): ___________________________________________________________________________

Sister(s): ____________________________________________________________________________

Children: ____________________________________________________________________________

**Social History**

Do you smoke? Yes No

How long have you smoked? ____________________________________________________________

Did you ever quit? Yes No For how long____________________

Do you drink alcohol? Yes No

If Yes, indicate the number of drinks (and type) you take in an average week.

(Please include beer and wine) ___________________________________________________________

Do you use other drugs? Yes No

Have you ever had a blood transfusion? Yes No

Marital Status: Single Married Widowed Divorced Widowed/Divorced/Remarried

Location prior to living in Myrtle Beach Area________________________________________________

Present Occupation/Past Occupations

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Review of Body Systems

Do you have a present or past history of any of the following (Please place an appropriate check next to each item):

| **General** | **Present** | **Past** | **Never** | **Pulmonary** | **Present** | **Past** | **Never** |
|---|---|---|---|---|---|---|---|
| Fever | | | | Shortness of breath | | | |
| Chills | | | | Wheezing | | | |
| Sweats | | | | Chronic cough | | | |
| Weight Change (loss or gain) | | | | Blood-streaked sputum | | | |
| Weakness | | | | Bronchitis | | | |
| Fatigue | | | | Pneumonia | | | |
| Swollen Glands | | | | Asthma | | | |
| Difficulty Sleeping | | | | Abnormal chest x-ray | | | |
| **Dermatologic** | | | | **Cardiovascular** | | | |
| New Skin Growths | | | | Chest pain | | | |
| Change in color, size of skin growth | | | | Chest pain w/walking exercise | | | |
| Rashes | | | | Heart murmur | | | |
| Mouth Sores | | | | Rheumatic fever | | | |
| Hair Loss | | | | Fainting | | | |
| Sun Sensitivity | | | | Swelling in ankles | | | |
| Fingernail changes | | | | Sleep on more than one pillow | | | |
| **Eyes, Ears, Nose, Throat** | | | | Calf or leg pain | | | |
| Wear Eye Glasses | | | | Varicose veins | | | |
| Eye Pain | | | | Abnormal electrocardiogram | | | |
| Hearing Loss | | | | **Gastrointestinal** | | | |
| Ringing in ears | | | | Nausea | | | |
| Ear infections | | | | Vomiting | | | |
| Sinus disorders | | | | Indigestion | | | |
| Post nasal drip | | | | Heartburn | | | |
| Nose bleeds | | | | Recurring diarrhea | | | |
| Phlegm in throat | | | | Frequent constipation | | | |
| Frequent colds or sore throats | | | | Recent change in bowel habits | | | |
| Hoarseness | | | | Blood in bowel movements | | | |
| Difficulty swallowing | | | | Black bowel movements | | | |
| **Breast** | | | | Jaundice | | | |
| Fibrocystic breast disease | | | | Hemorrhoids | | | |
| **Genitourinary** | | | | **Rheumatologic** | | | |
| Blood in urine | | | | Pain, stiffness or swelling in joints | | | |
| Pus in urine | | | | Bursitis | | | |
| Painful urination | | | | Arthritis | | | |
| Frequent urination | | | | Low back pain | | | |
| Urgent urination | | | | Low back stiffness | | | |
| Kidney infection | | | | Numbness or tingling in legs | | | |
| Bladder infection | | | | Foot pain | | | |
| Prostate infection | | | | | | | |
| Impotence | | | | | | | |
| Genital discharge | | | | | | | |

| **Neurologic** | **Present** | **Past** | **Never** | **Endocrine** | **Present** | **Past** | **Never** |
|---|---|---|---|---|---|---|---|
| Recurrent headaches | | | | Frequent urination | | | |
| Migraine headaches | | | | Urination at night | | | |
| Fainting | | | | Muscle cramps/weakness | | | |
| Dizziness | | | | Weight change | | | |
| Memory Loss | | | | Heat/cold intolerances | | | |
| Seizures | | | | Tremors | | | |
| Visual disturbances (blurred/double) | | | | Difficulty climbing stairs | | | |
| Speech difficulty | | | | Difficulty arising from chair | | | |
| Muscle weakness | | | | Palpitations | | | |
| Muscle paralysis | | | | Hair Loss | | | |
| Ringing in ears | | | | Excessive hair growth | | | |
| History of head injury | | | | | | | |

Person Completing Form ______________________ Relationship to Patient ______________________

Signature ______________________ Date ______________________

****************************************************************************************************

Hx. Reviewed with patient – no changes

Hx. Reviewed with patient – see note for changes

Physician Signature ______________________ Date ______________________

Hx. Reviewed with patient – no changes

Hx. Reviewed with patient – see note for changes

Physician Signature ______________________ Date ______________________

Hx. Reviewed with patient – no changes

Hx. Reviewed with patient – see note for changes

Physician Signature ______________________ Date ______________________