MERITAS HEALTH

Patient Medical History

Today's Date:

Patient Name: D.O.B.:

Referring Physician: Primary Care Physician:

Weight: Height: Feet Inches

Preferred Pharmacy (name and address): _____

_____

Past Medical History of: (please circle all the apply)

Diabetes	Arthritis	High Blood Pressure	Coronary Artery Disease	Hepatitis
Asthma	Jaundice	HIV	Pacemaker	Kidney Disease
Nervous Disorder	Pneumonia	Congestive heart failure	Bleeding tendencies	Tuberculosis

Diagnosis of Cancer – Type:_____ Other not listed: _____

Age at onset of menses:_____ Age at first pregnancy:_____ Age at Menopause:_____

IMMUNIZATIONS: Month/Year of last Pneumovax:_____ Month/Year of last Flu Vaccine:_____

PROCEDURES:

Date of last Colonoscopy (patients 50-75 years of age):

Date of last Mammogram (patients over 40 years of age):

SURGICAL HISTORY:

Operation	Date	Physician	Hospital

HOSPITALIZATIONS:

Illness	Date	Physician	Hospital

Patient Name: **Date of Birth**

CURRENT MEDICATIONS: (Include laxatives, herbal supplements and vitamins)

List of Allergies: (What type of reaction)

Are you allergic to shellfish or Iodine? YES or NO
Allergy to Latex? YES Or NO

FAMILY HISTORY: **PRESENT HEALTH OR CAUSE OF DEATH**

Father - Living or Deceased	Health Status:
Mother- Living or Deceased	Health Status:
Sisters – Living or Deceased	Health Status:
Brothers – Living or Deceased	Health Status:
Children – Living or Deceased	Health Status:

Patient Name: **Date of Birth**

SOCIAL HISTORY:

Marital Status: (Circle One):	Married	Single	Widowed	Divorced	Partner
Your Occupation:				How long:	
Do you use Tobacco now?	Yes or No	Past?	Type/Amount?	How Long?	
Do you drink alcohol now?	Yes or No	Type?	Frequency	How Long?	
Do you use chemical substances now? (circle one)	Yes or No			Past? Yes or No	

Hobbies:

*Please answer yes or no to whether you have experienced any of these symptoms within the past 6 months.

Constitutional Symptoms

Y N Fatigue
Y N Weight Loss
Y N Fever
Y N Chills
Y N Night Sweats

Eye Symptoms

Y N Vision problems
Y N Blurry Vision
Y N Seeing Double

Ear Symptoms

Y N Loss of Hearing
Y N Ringing in Ears
Y N Earache
Y N Ear Discharge

Nose & Throat Symptoms

Y N Nasal Discharge
Y N Nasal Congestion
Y N Sinus Pressure
Y N Sinus Pain
Y N Sore Throat
Y N Hoarseness
Y N Allergies
Y N Nosebleeds (epistaxis)

Pulmonary Symptoms

Y N Cough
Y N Coughing up Sputum
Y N Blood
Y N Shortness of Breath
Y N Wheezing
Y N Asthma

Cardiac Symptoms

Y N Chest pain
Y N Edema
Y N Palpitations

Gastric Symptoms

Y N Decrease in Appetite
Y N Heartburn
Y N Difficulty Swallowing
Y N Nausea
Y N Vomiting
Y N Diarrhea
Y N Constipation
Y N Abdominal Pain
Y N Rectal Bleeding
Y N Black Stools

GU Symptoms

Y N Urinary Frequency
Y N Urinary Incontinence
Y N Painful Urination
Y N Blood in Urine
Y N Nocturia (urination >2x per night)

Musculoskeletal Symptoms

Y N Joint Pain
Y N Muscle Aches
Y N Muscle Weakness
Y N Lower Back Pain

Neurological Symptoms

Y N Numbness
Y N Tingling
Y N Headache
Y N Dizziness
Y N Syncope
Y N Convulsions

Skin Symptoms

Y N Lesions

Breast Symptoms

Y N Discharge
Y N Lump

Endocrine Symptoms

Y N Excessive Thirst
Y N Intolerance to Heat
Y N Intolerance to Cold
Y N Easy Bruising
Y N Swollen glands in the Neck

Psych Symptoms

Y N Depression
Y N Anxiety