GULF COAST MEDICAL CARE PLLC

PATIENT MEDICAL HISTORY
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Patient Name: _____ Date of Birth: _____ Today's Date: _____

Who recommended you to this office? _____

HISTORY OF PRESENT ILLNESS:

What are you being seen for today: _____

_____

When did this begin: _____ Have you ever had this problem before: { }Yes { }No

Has any other physician seen you for this condition: { }Yes { }No Name: _____

Family Physician: _____

MEDICAL HISTORY: Please check all that apply

{ } Alcoholism
{ } Arthritis (Location) _____
{ } Asthma
{ } Blood Clots
{ } Blood Diseases { } Anemia { } Leukemia
{ } Blood Transfusion (when) _____
{ } Bronchitis
{ } Cancer (Type) _____
{ } Cataracts
{ } Colitis
{ } Diabetes
{ } Diverticulitis
{ } Drug Addition
{ } Emphysema
{ } Epilepsy
{ } Fracture/Broken Bones (where) _____
{ } Glaucoma
{ } Gout
{ } Heart Disease { } Mitral Valve Prolapse { } Murmurs
{ } Abnormal Rhythm { } Congestive Heart Failure
{ } Hepatitis
{ } Hernia
{ } High Blood Pressure
{ } High Cholesterol
{ } HIV Positive
{ } Kidney Disease { } Kidney Stones { } Kidney Cysts
{ } Latex Allergy
{ } Liver Cirrhosis
{ } Osteoporosis
{ } Parkinsonism
{ } Peptic Ulcers
{ } Prostate - { } Enlarged { } Inflammation { } Cancer
{ } Psoriasis
{ } Stroke
{ } Thyroid Disease
{ } Other _____

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PAST PROCEDURE: Please check all that apply & enter year, complications & left or right _____

PROCEDURE (Year, Left or Right, Complications)

{ } Appendectomy _____
{ } Arthroscopy _____
{ } Joint Replacement (Location): _____
{ } Breast PROCEDURE _____
{ } Cataract PROCEDURE _____
{ } Carpal Tunnel _____
{ } Skin Cancer _____

{ } Other: _____

PROCEDURE (Year, Left or Right, Complications)

{ } Back PROCEDURE _____
{ } Neck PROCEDURE _____
{ } Kidney PROCEDURE _____
{ } Pacemaker _____
{ } Hysterectomy _____
{ } Prostate PROCEDURE _____
{ } Cesarean Section _____
{ } D & C _____
{ } Gallbladder PROCEDURE _____
{ } Heart Bypass _____
{ } Heart Valve Replacement _____
{ } Tonsillectomy _____

MEDICATIONS – Please list all medications you are presently taking. _____

Example : Medication Synthroid Mg. .5 Dosage: 1 per day

Medication	Mg.	Dosage	Medication	Mg.	Dosage

SOCIAL HISTORY – Please check all that apply.

Drug Allergies: _____

Have you ever smoked tobacco: ☐ Yes ☐ No How much per day? _____ When did you quit? _____

Have you ever taken drugs not prescribed by a physician: ☐ Yes ☐ No What: _____

Are you currently taking any over the counter drugs? ☐ Yes ☐ No What: _____

Are you currently taking any herbal drugs? ☐ Yes ☐ No What: _____

Do you consume alcohol: ☐ Yes ☐ No How much: _____

Occupation: _____

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SYSTEM REVIEW: Please circle all that apply today

GENERAL:	Chills Weight loss	Sweats Weight gain	Anorexia	Fatigue
EYES:	Visual changes Discharge	Blurring Loss	Double vision Pain	Irritation Pain in sun
EAR NOSE THROAT:	Earache Post nasal drip	Ringing in ears Runny nose	Hearing loss Facial pressure	Sore throat Painful teeth
RESP:	Cough COPD	Shortness of breath Emphysema	Difficult breathing	Coughing blood
CARDIO/VASCULAR:	Chest pain Difficulty on Exercising	Palpitations PND	Syncope Edema	 Tachycardia
GASTRO INTESTINAL:	Vomiting Diarrhea Abdominal pain	Heart Burn Constipation	Reflux Black stools	Anorexia Bloody stools
GENITAL/URINARY:	Painful Urination Nighttime Discharge	Frequency Urination Testicle pain	Hesitancy Bloody Urine	Urgency Sores
GYNOCOLOGY:	Discharge Sores	Odor Irregular menses	Pelvic pain	Painful coitus
MUSCULOSKELETAL:	Back pain Decreased ROM	Joint Pain Altered gait	Joint swelling	Muscle Pain
SKIN:	Rash Bruising Pinpoint red/purple spots	Itching Bleeding under skin Hardened skin due to swelling	Dryness Redness of skin	Ulcers
ENDOCRINE:	Heat/cold intolerance	Increase thirst	Increase hunger	Increase urination
NEUROLOGY:	Weakness Dizziness	Abnormal sensation Headache	Painful skin	Seizures Tremor
PSYCHOLOGY:	Depression Suicidal thoughts Loss of contact with reality	Anxiety Agitation	Panic Unstable mood	Memory loss Insomnia
HEME/LYMPH/ID:	Abnormal bleeding Transfusion	Bruising HIV exposure	Swollen glands	Anemia

Sexually transmitted diseases: _____

OTHER: _____

FAMILY HISTORY:

Please list any blood relative and their relationship to you that have had any of the following (paternal or maternal):

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Rheumatoid Arthritis _____

Other _____