Veneta
Medical Clinic

Name: _____ DOB: _____ Date: _____

HISTORY OF PRESENT ILLNESS (reason for seeking medical attention):

_____

PAST/PERSONAL MEDICAL HISTORY:
Have you ever been diagnosed with any of the following? Check all that applies

GENERAL	HEART DISEASE	KIDNEY/BLADDER
☐ Allergies/ Hay fever	☐ Angina	☐ Incontinence
☐ Anemia	☐ Bypass Surgery	☐ Infection
☐ Bleeding Disorder Diabetes	☐ Congestive Heart Failure	☐ Prostate Disorder
☐ Blood Transfusion	☐ Heart Attack	☐ Stones
☐ Cancer: Type	☐ Heart Infection	
☐ Diabetes	☐ Irregular Heartbeat	MENTAL HEALTH
☐ Glaucoma	☐ Murmur	☐ Alcoholism
☐ High Blood Pressure	☐ Rheumatic Fever	☐ Anxiety
☐ High Cholesterol	☐ Valve Replacement	☐ Depression
☐ Migraines/ Headache		☐ Drug Abuse
☐ Paralysis	GASTROINTESTIONAL	☐ Nervous Breakdown
☐ Seizure Disorder	☐ Bleeding	☐ Mental Illness
☐ Stroke	☐ Colitis	
☐ Thyroid Problems	☐ Diverticulosis	MUSCULOSKELETAL
	☐ Gallstones	☐ Arthritis
INFECTIOUS DISEASE	☐ Hemorrhoids	☐ Gout
☐ AIDS or HIV positive	☐ Hepatitis: Type	☐ Joint Pain
☐ Tuberculosis	☐ Hiatal Hernia	
☐ Sexually Transmitted Disease	☐ Irritable Bowel Syndrome	
	☐ Polyps	
LUNG DISEASE	☐ Spastic Colon	
☐ Emphysema	☐ Ulcers	
☐ Asthma		
☐ Chronic Bronchitis	GYNECOLOGICAL	
☐ Pneumonia	☐ Abnormal PAP	
☐ Asbestosis	☐ Cyst	
	☐ Endometriosis	
	☐ Irregular Bleeding	

Other doctors involved in my care: _____

SURGERIES (Please list surgeries and date): _____

_____

_____

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SURGERIES (Please list surgeries and date): _____

_____

TRAUMA: _____

HOSPITALIZATIONS: _____

FAMILY HISTORY: Please fill in name, age and whether they are living or deceased.

Children: _____
_____
_____
Mother: _____
Father: _____
Siblings: _____
_____
_____

Has anyone in your family been diagnosed with (list relationship):
Breast Cancer: _____
Colon Cancer: _____
Deep Vein Thrombosis: _____
Diabetes: _____
Heart Disease: _____
Stroke: _____

CURRENT MEDICATIONS (prescription name and dosage; including supplements and vitamins):

_____

_____

ALLERGIES (Include medicines, foods, bee stings, hay fever):

_____

_____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Separated Widowed

Occupation: _____

Religion: _____

Education: _____

Birth Place: _____

HABITS: (Please state "yes" or "no" and specify how much/how often)

Tobacco: _____

Alcohol: _____

Drugs: _____

Coffee: _____ Tea: _____ Pop: _____

Name: _____ DOB: _____ Date: _____

PUT A CHECK NEXT TO THOSE STATEMENTS YOU WOULD ANSWER **YES** TO

GENERAL	CHEST	WOMEN
Appetite: Good___ Fair___ Poor___	Abnormal chest x-ray	Last pap smear:
Difficulty with sleeping	Abnormal EKG	Mammogram:
Frequent or severe headaches	Angina	Colorectal screening:
Handicapped in any way	Chest pain or discomfort	Bone density test:
Recurrent fever or chills	Chronic or frequent cough	Age of menopause:
Severe stress	Cough when lying down	First day of last period:
Significant weight change	Coughing up blood	Any bleeding between periods
Unconscious spells	Enlarged veins in legs	Ever had an abnormal pap
	Heart murmur	Vaginal itch or discharge
MENTAL HEALTH	High blood pressure	Number or pregnancies:
Considered suicide	Leg cramps at night	Any miscarriages
Crying episodes	Leg cramps when walking	Any C-sections
Depressed	Palpitations or fluttering heart	Any abortions
Disturbing thoughts/ feelings	Shortness of breath	Breast lumps or discharge
Lonely	Swelling of ankles, feet, hands	Hot flashes
Other emotional problems	Wheezing	Type of contraception:
Problems with work or family		
	GASTRO-INTESTINAL	**MEN**
EYES, EARS, NOSE, THROAT	BM's ever black or bloody	Penile discharge
Colds that last for months	Constipation	Problems with intercourse
Difficulty hearing	Ever been jaundiced	Prostate problems
Irritated or watery eyes	Ever vomited blood	Swells or lumps in testicles
Mouth sores	Frequent diarrhea	Urine stream very weak or slow
Nasal allergies/ hay fever	Frequent stomach pains	
Problems with teeth/gum	Frequent use of antacid	**MUSCULO-SKELETAL**
Problems with wax or discharge	Gall bladder pain	Backaches
Prolonged hoarseness	Heartburn	Joint aches and/or swelling
Recurrent nose bleeds	Hemorrhoids	Muscle spasm or weakness
Ringing in ears	Painful bowel movements	Trembling or shaking
Sinus troubles	Urinary incontinence	
Spots or light before eyes		**ENDOCRINE**
Stiff or painful neck	**GENITO-URINARY**	Excessive thirst or hunger
Strange taste or loss of taste	# of times getting up to urinate during sleep	Hot flashes
Unusual lumps in neck	Constant feeling you have to urinate	Inability to stand heat or cold
Worse or changing vision	Difficulty starting urine stream	Recent change in hair texture
	Every had kidney stones	Skin changes
NERVOUS SYSTEM	Ever had black/brown/bloody urine	
Ever been knocked unconscious	Pain or burning when urinating	**SKIN**
Fainting spells	Problems with intercourse	Bothersome calluses
Frequent dizziness	Venereal disease past/present	Change in wart or mole
Muscle weakness	Wet pants when cough or sneeze	Dry skin
Poor memory		Hives
Seizures	**CHOLESTEROL**	Recurrent rashes
Tingling or numbness in arms	High Cholesterol	
Tingling or numbness in legs	High Triglycerides	
	High LDL	
	High HDL	