REGAL PARK MEDICAL CENTER

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PATIENT MEDICAL HISTORY

We are here to help! If you are needing assistance in filling out this section or any portion of the packet please inform the front desk.

ANYTHING LEFT BLANK OR UNANSWERED WILL BE SEEN AS UNAPPLICABLE TO THE PATIENT.

Date: _____

Name: _____ **DOB:** _____

PERSONAL MEDICAL HISTORY

MEDICAL PROBLEMS

These refer to specific medical problems diagnosed by a previous doctor. Check any of the following that applies to yourself only, whether it be now, in the past, or both.

◯ **Anemia**	◯ **Diabetes**	◯ **Stroke**	◯ **Stroke**
◯ **Arthritis**	◯ **Emphysema (COPD)**	◯ **High Blood Pressure**	◯ **Thyroid Problems**
◯ **Asthma**	◯ **Gout**	◯ **Kidney Disease**	◯ **Blood Vessel Disease**
◯ **Cancer**	◯ **Heart Attack**	◯ **Seizures**	◯ **Liver Infection (Hepatitis)**

PREVIOUS INJURIES, HOSPITALIZATIONS, & SURGERIES

Check and/or fill out any of the following that applies to your medical history. Give exact dates, if possible, or closest estimated date or time period.

Check all that apply: ◯ **No prior surgeries** ◯ **No prior hospitalizations** ◯ **No prior injuries**

1 Please specify: ◯ **Injury** ◯ **Hospitalization** ◯ **Surgery** **Occuring Date:** _____

Injury: _____ **Reason for Hospitalization:** _____

Surgery Performed: _____ **Performing Doctor:** _____

2 Please specify: ◯ **Injury** ◯ **Hospitalization** ◯ **Surgery** **Occuring Date:** _____

Injury: _____ **Reason for Hospitalization:** _____

Surgery Performed: _____ **Performing Doctor:** _____

3 Please specify: ◯ **Injury** ◯ **Hospitalization** ◯ **Surgery** **Occuring Date:** _____

Injury: _____ **Reason for Hospitalization:** _____

Surgery Performed: _____ **Performing Doctor:** _____

4 Please specify: ◯ **Injury** ◯ **Hospitalization** ◯ **Surgery** **Occuring Date:** _____

Injury: _____ **Reason for Hospitalization:** _____

Surgery Performed: _____ **Performing Doctor:** _____

*If you're needing to add any additional injuries, hospitalizations, and/or surgeries, please **request a continuation page** to do so.*

CURRENT MEDICATIONS

List all prescription and non-prescription medications, vitamins, and supplements you currently take.

Check all that apply: ◯ No current medications ◯ No current vitamins ◯ No current supplements

1 RX Name: _____ **Dosage:** _____

2 RX Name: _____ **Dosage:** _____

3 RX Name: _____ **Dosage:** _____

4 RX Name: _____ **Dosage:** _____

5 RX Name: _____ **Dosage:** _____

*If you're needing to add any additional medications, etc. to your current medications list, please **request a continuation page** to do so.*

ALLERGIES & DRUG REACTIONS

List all allergies and drug reactions that you have and have had in the past.

Check all that apply: ◯ No allergies ◯ No drug reactions

1: _____ **4:** _____

2: _____ **5:** _____

3: _____ **6:** _____

*If you're needing to add any additional allergies, etc. to your allergies & drug reactions list, please **request a continuation page** to do so.*

SOCIAL HISTORY (9 QUESTIONS)

Check all answers that are applicable to you. Please answer all questions honestly and to your best ability.

1: Average alcohol consumption: ◯ Never ◯ Rarely ◯ Sometimes ◯ Frequently

2: Average caffeine consumption: ◯ Never ◯ Rarely ◯ Sometimes ◯ Frequently

3: Do you currently use non-prescribed narcotics, depressants, stimulants, or hallucinogens? ◯ Yes ◯ No

4: Check all that apply to you: ◯ I live alone ◯ I am married and live with my spouse ◯ Other

5: Do you live in an assisted living facility? ◯ Yes ◯ No

6: Are you currently living with and caring for a family/household member? ◯ Yes ◯ No

6-1: If yes, please specify: ◯ Parent ◯ Sibling ◯ Child ◯ Other

7: Are you currently unable to drive a motor vehicle? ◯ Yes ◯ No

8: Do you currently smoke cigarettes? ◯ Yes ◯ No

8-1: If no, do you have a previous history of smoking cigarettes? ◯ Yes ◯ No

8-1a: If yes, how long it has been since you stopped? _____ ◯ Years ◯ Months ◯ Weeks ◯ Days

9: Have you ever traveled outside of the country? ◯ Yes ◯ No

9-1: If yes, how long were you out of the country? _____ ◯ Years ◯ Months ◯ Weeks ◯ Days

COMPLETE SYMPTOM HISTORY (15 categories)

Check all of the following that applies to yourself only, whether it be now, recently, or in the past year.

SYSTEMIC
- ◯ generalized pain
- ◯ feeling tired
- ◯ fever
- ◯ chills
- ◯ weight change

other related symptoms:

_____
_____

HEAD-RELATED
- ◯ headache
- ◯ sinus pain
- ◯ sinus pressure
- ◯ cheek swelling
- ◯ facial pain

other related symptoms:

_____
_____

GASTROINTESTINAL
- ◯ appetite change
- ◯ nausea
- ◯ heartburn
- ◯ abdominal pain
- ◯ diarrhea

other related symptoms:

_____
_____

OTOLARYNGEAL
- ◯ hearing loss
- ◯ earache
- ◯ nasal discharge
- ◯ throat pain
- ◯ oral pain

other related symptoms:

_____
_____

EYE
- ◯ blind spot(s)
- ◯ seeing double
- ◯ eye irritation
- ◯ eye pain
- ◯ growth on eye

other related symptoms:

_____
_____

NECK
- ◯ pain
- ◯ muscle tightness
- ◯ stiffness
- ◯ enlargement
- ◯ lump or swelling

other related symptoms:

_____
_____

CARDIOVASCULAR
- ◯ chest pain
- ◯ chest discomfort
- ◯ heart palpitations
- ◯ cold hands
- ◯ cold feet

other related symptoms:

_____
_____

HEMATOLOGIC
- ◯ bleeds easily
- ◯ bruises easily
- ◯ excessive bleeding
- ◯ large bruises
- ◯ tender swollen areas on skin

other related symptoms:

_____
_____

PULMONARY
- ◯ asthma
- ◯ chest congestion
- ◯ difficulty breathing
- ◯ coughing
- ◯ coughing up blood

other related symptoms:

_____
_____

PSYCHOLOGICAL
- ◯ anxiety
- ◯ mood changes
- ◯ depression
- ◯ insomnia
- ◯ unusual behavior (specify below)

other related symptoms:

_____
_____

ENDOCRINE
- ◯ excessive thirst
- ◯ excessive sweating
- ◯ hot flashes
- ◯ unable to perform sexually
- ◯ unable to get pregnant

other related symptoms:

_____
_____

GENITOURINARY
- ◯ blood in urine
- ◯ frequent urination
- ◯ difficulty urinating
- ◯ genital pain or swelling
- ◯ painful urination

other related symptoms:

_____
_____

SKIN
- ◯ unusually dry skin
- ◯ itchy skin
- ◯ skin lesion(s)
- ◯ nail discoloration
- ◯ abnormal nail thickness

other related symptoms:

_____
_____

MUSCULOSKELETAL
- ◯ joint pain
- ◯ joint swelling
- ◯ joint stiffness
- ◯ unable to straighten joint
- ◯ muscle aches

other related symptoms:

_____
_____

NEUROLOGICAL
- ◯ dizziness
- ◯ fainting
- ◯ memory disturbances
- ◯ sensory disturbances
- ◯ convulsions

other related symptoms:

_____
_____

FAMILY MEDICAL HISTORY

COMPLETE SYMPTOM HISTORY (15 categories)

Check all of the following that applies to your family only, whether it be now, in the past, or both.

ANEMIA
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

ARTHRITIS
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

ASTHMA
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

CANCER
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

DIABETES
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

EMPHYSEMA (COPD)
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

GOUT
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

HEART ATTACK
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

LIVER INFECTION (HEPATITIS)
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

HIGH BLOOD PRESSURE
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

KIDNEY DISEASE
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

SEIZURES
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

STROKE
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

THYROID PROBLEMS
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother

BLOOD VESSEL DISEASES
- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Paternal Grandfather
- ◯ Paternal Grandmother
- ◯ Maternal Grandfather
- ◯ Maternal Grandmother