

## PATIENT MEDICAL PROFILE

Date: \_\_\_/\_\_\_/\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_

Name: \_\_\_\_\_

### Health history

Anesthesia problems      **Y N**  
 Asthma                              **Y N**  
 Stroke                                **Y N**  
 Heart Disease                      **Y N**  
 Diabetes                              **Y N**  
 Arthritis                              **Y N**  
 Acid Reflux                          **Y N**  
 Seizures                              **Y N**  
 Seasonal Allergies                **Y N**  
 Mental Illness                      **Y N**  
 Kidney disease                      **Y N**  
 Kidney stones                        **Y N**  
 Cancer                                **Y N**  
 Bleeding disorders                **Y N**  
 Alcoholism                          **Y N**  
 Serious injury                       **Y N**  
 Lung disease                        **Y N**  
 Tuberculosis                        **Y N**  
 Phlebitis                              **Y N**  
 Anemia                                **Y N**  
 HIV/AIDS                            **Y N**  
 Liver disease                        **Y N**  
 Hepatitis                              **Y N**  
 Thyroid disease                      **Y N**  
 Stomach ulcer                       **Y N**  
 Insomnia                              **Y N**  
 Other illnesses                      **Y N**

#### List all surgeries with date (yr)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Current Medications w dosages

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Social History

Smoke **Y N** Packs/d \_\_\_ Years \_\_\_  
 Alcohol: Never \_\_\_ Occasional \_\_\_  
 Drug use: Ever **Y N** Current **Y N**

### Family History

Stroke                                **Y N**  
 Heart Disease                      **Y N**  
 High blood pressure               **Y N**  
 Diabetes                              **Y N**  
 Arthritis                              **Y N**  
 Anesthesia problems               **Y N**  
 Seizures                              **Y N**  
 Ovarian cancer                      **Y N**  
 Breast cancer                       **Y N**  
 Colon cancer                        **Y N**  
 Cancer other                        **Y N**  
 Bleeding disorder                  **Y N**  
 Mental illness                       **Y N**  
 Thyroid disease                      **Y N**

#### Parents:

Mother: living **Y N**  
 Father: living **Y N**  
 Siblings: living **Y N**

#### Cause of death

### Menstrual History

Age of onset: \_\_\_\_\_  
 1<sup>st</sup> day of last period: \_\_\_\_\_  
 Are your periods monthly? \_\_\_\_\_  
 How many pads/tampons per day? \_\_\_\_\_  
 Cramps **Y N** Severe **Y N**  
 Excessively heavy **Y N**  
 Ever bleed through clothing **Y N**  
 Clots **Y N**

### Urinary History

Need to empty too frequently? **Y N**  
 Any urgency? **Y N** Accidents? **Y N**  
 Leak urine w cough, strain, exercise? **Y N**  
 Need to urinate after going to bed? **Y N**  
 Do you wear a pad daily? **Y N**

### Marital History

Married \_\_\_ Single \_\_\_ Divorced \_\_\_  
 No. of children living \_\_\_ Deceased \_\_\_  
 No. of grandchildren \_\_\_

### Obstetrical History

Total number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_  
 Number of stillbirths \_\_\_\_\_  
 Number of premature births \_\_\_\_\_  
 Number of vaginal delivers \_\_\_\_\_  
 Number of C/sections \_\_\_\_\_  
 Any complications? Explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Review of Systems

Chills or fever                      **Y N**  
 Night sweats                        **Y N**  
 Unexplained weight loss        **Y N**  
 Poor appetite                        **Y N**  
 Fatigue                                **Y N**  
 Frequent headaches               **Y N**  
 Dizzy spells                         **Y N**  
 Pass out episodes                 **Y N**  
 Insomnia                              **Y N**  
 Chest pain                            **Y N**  
 Shortness of breath                **Y N**  
 Persistent cough                  **Y N**  
 Difficulty swallowing              **Y N**  
 Irregular heartbeat                **Y N**  
 Frequent heartburn                **Y N**  
 Nausea/vomiting                  **Y N**  
 Change in bowel habits            **Y N**  
 Rectal bleeding                     **Y N**  
 Black tarry stools                  **Y N**  
 Chronically loose stools          **Y N**  
 Frequent constipation            **Y N**  
 Joint or muscle aches              **Y N**  
 Swollen glands                      **Y N**  
 Easy bruisability                  **Y N**  
 Bleeding problems                **Y N**  
 Hair loss                              **Y N**  
 Constant thirst                     **Y N**  
 Rashes                                **Y N**  
 Hives                                 **Y N**  
 Anxiety/panic spells               **Y N**  
 Depression                          **Y N**