Southern Medical Group
Medical History

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Date: ____________________

Patients Name: ____________________ **Age:** __________ **Sex:** ________

Occupation: ____________________ **Race:** __________ **Religion:** __________

1. Why are you here? (What are your symptoms? Describe in detail)

____

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2. Past Surgical History (Describe in detail)

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3. Past Medical History (Circle Y-Yes or N-No)

High Blood Pressure	Y N	Arthritis	Y N
Stroke	Y N	Kidney Failure	Y N
Diabetes	Y N	Thyroid	Y N
Emphysema/COPD	Y N	Depression	Y N
Asthma	Y N	Ulcers	Y N
Heart Disease	Y N	Other: ____________________	

4. Family History/Illness-List All (Refer to list above)

Mother ____________________

Father ____________________

Brother(s): ____________________

Sister(s): ____________________

Other: ____________________

5. Medication List (List date started and dosage)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

6. Immunizations (Year and Date)

Flu: ____________________ Pneumovax: ____________________ Tetanus: ____________________

Hepatitis: __________ Other: ____________________

7. Allergies (List allergies and reactions.)

____

____

____

8. Alcohol:
   Social: ______ Occasionally: ______ Rare: ______ Never: _______

9. Tobacco:
   Cigarettes: _____ Cigars: ______ Pipe: ______ How Much? ___________

Review of Symptoms (Do you experience any of the following? Circle all that apply)

General:
Weight Change Weight Loss Fever/Chills Night Sweats

Heent:
Blurred Vision Nosebleeds Sinusitis Ringing Ears
Hoarseness Deceased Hearing Vertigo

Chest:
Shortness of Breath Chronic Bronchitis Cough Asthma Wheezing

Cardiac:
Edema/Swelling Rheumatic Heart Dis. Fast/Slow Heartbeats Murmer
Irregular Heartbeats Chest Pain Fainting Leg Cramps

G.I.
Nausea/Vomiting Abdominal Pain Food Intolerance Heartburn
Ulcer Difficulty Swallowing Hesitancy Diarrhea/Constipation
Recent Change in Bowels Hesitancy

G.U. (Pain or difficulty urinating)
Urine Leakage Impotence Discharge

Nerves:
Headaches Weakness Numbness Double Vision

Psych:
Depression Anxiety Insomnia

Joint/Muscles:
Joint Pain/Stiffness Arthritis Muscle Weakness Back Pain

Sexual:
Last Menstrual Period ________________ Hot Flashes

Breast:
Mass/Nodule/Discharge

Skin:
Change in Moles itching Rash Other :__________