Weiss Memorial Hospital
Ambulatory Medical History

General Information

Name: ____ Social Security #: __ __ __ / __ __ / __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __ Age: _______ Sex: ☐ M ☐ F Date: ___________________

Language(s) spoken: ☐ English ☐ Spanish ☐ Russian ☐ Other: ________________________________

Medical History (Check all current or past problems.)

Allergies/hay fever
Anemia
Anxiety problem
Arthritis
Asthma/wheezing
Back pain
Bleeding disorder
Blood transfusion
Bone/joint injuries
Cancer
Chicken pox
Convulsions/seizures
Dementia/memory loss

Dental/oral disease
Diabetes
Depression
Ear/hearing problems
Eye/vision problems
Foot problems
Gall bladder disease/stones
Gastritis/ulcer
Gout
Headaches/migraine
Heart disease
Heart rhythm problem
Hemorrhoids

Hepatitis
Hernia
Herpes
High blood pressure
High cholesterol
HIV/AIDS
Kidney disease/stones
Liver disease
Lung disease
Menstrual problems
Mental illness
Osteoporosis
Pneumonia
Prostate disorder

Sexual problems
Sexually transmitted disease
Skin disease/sores
Sleep problems
Stomach/digestive disease
Stroke
Thyroid disease
Tuberculosis (or positive TB test)
Urinary problem

Please give details of any items checked, or add information about other problems if they are not listed:

____

____

____

____

Surgical History (List the date and type of any past surgeries.)

Date	Surgery	Date	Surgery

Medications (List any medications you use, prescription or non-prescription, including the dose and how often you take it. Please include all types of medicine, including creams and eye drops.)

Medication	Dose and Frequency	Medication	Dose and Frequency

Are you taking or using anything else for your health or to treat symptoms (such as vitamins, herbs or weight loss products? Please list them: ____

____

Allergies and Adverse Reactions (List any substances that have caused a bad reaction, and describe the reaction. Include prescription or non-prescription medicines, foods, plants or other materials.)

Substance	Reaction	Substance	Reaction

Personal History and Habits (Please note that while these questions are personal, your responses will be kept confidential. If you feel uncomfortable with a question, you may leave it blank.)

Occupation: ____________________ Are you? ☐Single ☐Married ☐Divorced ☐Widowed
Do you have children? ☐Yes ☐No If so, what are their ages? ____________________
Who lives with you in your home? ____________________
At home, do you need help getting around, dressing, bathing, using the bathroom, or eating food? ☐Yes ☐No
If so, what do you need help with? ____________________

Safety

Do you feel unsafe or threatened in any way (at home, work or otherwise)? ☐Yes ☐No
Have you ever been the victim of violence or abuse (including sexual abuse)? ☐Yes ☐No
Do you or other family members keep gun(s) in the home? ☐Yes ☐No
Do you wear a seatbelt when you drive? ☐No ☐Yes ☐Sometimes
Do you have smoke detector(s) in your home? ☐No ☐Yes ☐Don't know

Substances

Do you use tobacco? ☐Yes ☐No If no, have you ever used tobacco? ☐Yes ☐No
If "yes": ☐ Cigarettes Amount and for how long: ____________________
☐ Cigars Amount and for how long: ____________________
☐ Chewing tobacco Amount and for how long: ____________________
In the past year, have you ever drunk or used drugs more than you meant to? ☐Yes ☐No
In the past year, have you ever thought you should cut down on your drinking or drug use? ☐Yes ☐No
Do you ever get annoyed or angry when people talk to you about your drinking/drug use? ☐Yes ☐No
Do you ever feel guilty about your drinking/drug use? ☐Yes ☐No
Have you ever had an "eye-opener" (morning drink) to get started first thing in the morning? ☐Yes ☐No
About how many standard drinks do you have in a typical week? (A standard drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor) ☐1-7 ☐8-10 ☐11-13 ☐14-20 ☐21-30 ☐31-40 ☐41 or more

Other Health Habits

Do you exercise? ☐Yes ☐No If yes, what activities and how often? ____________________
When was your last dental exam? ____________ When was you last vision exam? ____________
Have you recently or do you often travel outside the U.S.? ☐Yes ☐No If so, where? ____________

Nutrition

What is your usual weight? ____________ What is your usual height? ____________
Have you unintentionally gained or lost 10 pounds in the last month? ☐Yes ☐No How much? ________
Have you had decreased food intake for more than one week? ☐Yes ☐No
Do you have difficulty swallowing? ☐Yes ☐No
Do you have any pressure sores or skin ulcers? ☐Yes ☐No
Are you on a modified or special diet, or on tube feeding? ☐Yes ☐No
If yes, please describe: ____________________
(For **women**): Are you pregnant or breast-feeding? ☐Yes ☐No

Family History (For any past or current illness in your family, write the relation of the family member):

Illness	Family Member(s)	Illness	Family Member(s)
Alcohol/substance abuse		High cholesterol	
Cancer; type: ________		Psychiatric illness	

Diabetes		Stroke	
Heart disease/attack		Tuberculosis	
High blood pressure		Other: ______________	

Obstetric/Gynecologic History (for **women** only)

Age of first period? __________ If you no longer have periods, at what age did they stop? ____________
Please list: Total # of pregnancies? __________ Abortions? __________ Miscarriages? __________
Do you plan to get pregnant within the next year? ☐Yes ☐No
Are you using any birth control? ☐Yes ☐No If yes, what type? ______________________________

Cancer Screening

Colon cancer (for **men and women over age 50**):
Have you ever had tests to detect colon cancer? ☐Yes ☐No ☐Don't know

Cervical and Breast Cancer (for **women** only):
When was your last Pap smear? Year: ______________ ☐Don't remember ☐Never
Have you ever had an abnormal Pap smear? ☐Yes ☐No ☐Don't know
When was your last mammogram? Year: ______________ ☐Don't remember ☐Never
Have you ever had an abnormal mammogram? ☐Yes ☐No ☐Don't know

Immunizations (If known, when did you last receive):

Tetanus booster: ☐Yes, Year: _____________ ☐Never ☐Don't know
Flu vaccine: ☐Yes, Year: _____________ ☐Never ☐Don't know
Pneumonia vaccine: ☐Yes, Year: _____________ ☐Never ☐Don't know

Advance Directives

Do you have a Living Will (instructions about how much medical care you want given if you get very sick)? ☐Yes ☐No ☐Don't know
Do you have a Power of Attorney for health care (instructions about who you want to make medical decisions for you if you are not able to make them)? ☐Yes ☐No ☐Don't know
Would you like more information about a Living Will or a Power of Attorney? ☐Yes ☐No

Symptoms (Check any of the following if they describe your current or recent symptoms.)

General
- Anxious/nervous
- Appetite change
- Depression
- Excessive thirst
- Fainting
- Fatigue
- Fever or chills
- Sleep problem
- Sweats

Eye, Ear, Nose, Throat
- Bleeding gums
- Dental pain
- Earache
- Hearing problem
- Hoarse voice
- Runny nose
- Vision problem

Respiratory
- Cough
- Shortness of breath
- Wheezing

Cardiovascular
- Chest pain
- Leg swelling
- Palpitations
- Poor circulation
- Varicose veins

Gastrointestinal
- Abdominal pain
- Constipation
- Diarrhea
- Gas
- Heartburn/indigestion
- Hemorrhoid symptoms
- Nausea/vomiting
- Rectal bleeding

Muscle/Joint/Bone
- Joint pain
- Joint swelling
- Muscle pain/weakness

Neurologic
- Dizziness/vertigo
- Headache
- Memory problem
- Numbness/tingling
- Seizures
- Weakness

Skin/Hair/Nails
- Bruise easily
- Growth/mass/lump
- Hair changes
- Itching
- Nail problem
- Rash
- Sore that won't heal

Urinary
- Bladder control problem
- Blood in urine
- Frequent urination
- Painful urination

Women Only
- Abnormal vaginal discharge
- Bleeding between periods
- Breast lump
- Hot flashes
- Irregular periods
- Painful intercourse
- Severe menstrual pain

Men Only
- Erection problem
- Lump in testicle
- Penis discharge
- Sore(s) on genitals

Reviewed by:

____ ____________________________

PHYSICIAN **DATE**