

NEXT ERA HEALTH & WELL-BEING MEDICAL HISTORY

Date: _____

Name: _____

DOB: _____

Present symptoms or reason for visit:

Family History:

Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
High Cholesterol	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Lung Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Tuberculosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Kidney Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Liver Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Obesity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Bleeding Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Thyroid Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Aneurysm	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Epilepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Muscular Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Gout	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Crohn's Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Ulcerative Colitis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Ulcers	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Rheumatoid Arthritis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Lupus	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Mental History	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Drug/Alcohol Problem	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Suicide	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents
Other _____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Grandparents

Social History:

Ethnicity _____
 Armed forces
 Exercise regularly _____

Tobacco Use (how much) _____
 Drink alcohol (how much) _____
 Occupation _____

Marital History: Single Married Divorced Widowed

Sexual History (helps us to assess your risks for certain diseases):

Heterosexual Homosexual Bisexual

Have you had the chicken pox? yes no

Cage Questionnaire: Please circle Yes or No

Have you ever felt you should cut down on your drinking? **Yes / No**

Have people annoyed you by criticizing your drinking? **Yes / No**

Have you ever felt bad or guilty about your drinking? **Yes / No**

Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? **Yes / No**

***Past History:* Please check any conditions that have occurred to you in the past**

Adult Illnesses:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Mental Health Issues | |
| <input type="checkbox"/> Drug or Alcohol Addiction | <input type="checkbox"/> Sexually Transmitted Disease | | |
| <input type="checkbox"/> Other _____ | | | |

Medications, Vitamins and Supplements:

Name of medication	Dosage	How Many Times a Day Taken

Drug Allergies _____

All previous operations (when and what for)

1. _____

2. _____

3. _____

4. _____

***Review of Systems:* Please check any symptoms that you are currently experiencing**

Head and Neck

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Recent skull fracture | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Passing out | <input type="checkbox"/> Double vision | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Trouble hearing | <input type="checkbox"/> Discharge from ear |
| <input type="checkbox"/> Trouble with teeth | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Pain in neck | <input type="checkbox"/> Stiffness in neck |
| <input type="checkbox"/> Thyroid trouble | | | |

Respiratory

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Exposure to Tuberculosis |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Chills | <input type="checkbox"/> Pneumonia | |

Cardiac

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Shortness of breath at rest/at night | | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Triglycerides |
| <input type="checkbox"/> Heart murmur | | | |

Gastrointestinal

- | | | | |
|--|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Vomit blood |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Change in stool | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Recent change in weight | |
| <input type="checkbox"/> Most Recent Colonoscopy _____ | | | |

Genitourinary

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Excess thirst | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Change in urinary stream | | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Hesitancy | <input type="checkbox"/> Awaken with urge to urinate/How Often? _____ | | |
| <input type="checkbox"/> Dribbling | <input type="checkbox"/> Incontinence | | |

Gynecological

- | | |
|--|---|
| Last menstrual period _____ | Last pelvic and pap smear _____ |
| Last Mammogram _____ | Last Bone Density _____ |
| <input type="checkbox"/> Unusual Vaginal discharge or odor | <input type="checkbox"/> Unusual Vaginal bleeding |

Skin

- | | | | |
|-------------------------------|----------------------------------|---|---|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Itching | <input type="checkbox"/> History of skin cancer | <input type="checkbox"/> Skin disorders |
|-------------------------------|----------------------------------|---|---|

Miscellaneous

- | | | | |
|-----------------------------------|-------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of memory |
|-----------------------------------|-------------------------------------|----------------------------------|---|

Musculoskeletal

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Swelling joints | <input type="checkbox"/> Muscle Pain |
|---|--|--------------------------------------|