

MEDICAL HISTORY FORM

Patient Name _____ Today's Date _____

Have you been under a doctor's care in the last two years? Yes No

If yes, for what? _____

Have you ever been hospitalized, had a major operation, or a serious illness? Yes No

If yes, for what? _____

Have you taken any medications during the past year? Yes No

If so, what medicine? _____

Do you have any allergic reaction to any medication? Yes No

If yes, please list _____

Do you have any of these conditions. Check (✓) Yes or No.

Heart (disease) Yes No Asthma Yes No

Chest pain Yes No Allergies Yes No

High blood pressure Yes No AIDS Yes No

Stroke Yes No HIV Yes No

Diabetes (Type I/Type II) Yes No Emphysema Yes No

Cancer Yes No Tuberculosis Yes No

Have you lost or gained more than 10 pounds in the last year? Yes No

If so, give details. _____

Do you smoke? Yes No

Women: Are you pregnant? Yes _____ Months No

A Read the medical history form. Answer the questions. Circle the correct answer.

MEDICAL HISTORY FORM

Patient Name Silva, Martim Date of Birth 6/18/72

Reason for visit today: Coughing, difficult to breathe

How long have you had these symptoms? Three days

Have you been under a doctor's care in the last two years? Yes No

If yes, for what? heart problems and high blood pressure

Have you ever been hospitalized, had a major operation, or had a serious illness? Yes No

If yes, for what? Asthma

Please list any medications you are currently taking: aspirin, diuretic

Are you allergic to any medications? Yes No

If yes, please list: _____

Do you now or have you ever had:

<input type="checkbox"/> Heart problems	<input type="checkbox"/> Emphysema
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Asthma
<input type="checkbox"/> HIV/AIDS	

In the past month, have you had any of the following symptoms?

<input checked="" type="checkbox"/> Weight gain or loss	<input type="checkbox"/> Dizziness
<input checked="" type="checkbox"/> Chest pain	<input type="checkbox"/> Nausea
<input checked="" type="checkbox"/> Shortness of breath	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Fainting	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Headaches	

B **WRITE ABOUT IT.** Go online and find information about allergies to medication. What are three common drug allergies? What are some common symptoms for these allergies.

Drug	Symptom of allergy
Aspirin	Rash

C **APPLY.** Imagine you're a doctor. You took notes during Ms. Kim's appointment. Use these notes to fill out these sections of her medical history.

+ Oakdrive Health Center, Rockdale ...

Patient: Ann Kim
Complaining of stomachache. Symptoms have worsened over the last three days. Severe pain this morning. No nausea or vomiting. Previous history of stomach pain late last year. Ask for patient notes from Dr. Lin in Beechwood Medical Center, Springfield.

Reason for patient's visit:

How long has the patient had these symptoms?

Has the patient been under a doctor's care in the last two years? Yes No.
If yes, for what?
