WHAT SERIOUS MEDICAL CONDITION OR DISEASE DO YOU HAVE OR HAVE HAD PREVIOUSLY

	YES	NO		YES	NO
HEADACHES (FREQUENT)			ANEMIA		
EYE PROBLEMS			WEIGHT GAIN / LOSS		
FAILING VISION			CANCER		
HEARING LOSS					
THYROID LOSS			TB		
THYROID DISEASE			PNEUMONIA / PLEURISY		
STROKE			VALLEY FEVER		
DIZZY OR FAINT					
CONVULSIONS / SEIZURES			BLOODY OR BLACK STOOLS		
HAY FEVER			JAUNDICE / HEPATITIS		
HIVES / RASHES			GALL BLADDER TROUBLE		
TONSIL PROBLEMS			DIARRHEA		
ENLARGED GLANDS			CONSTIPATION		
ACNE			FREQ. ABDOMINAL PAIN		
			CHANGE IN BOWEL HABITS		
PERSONAL HISTORY OF HEART ATTACK			INDIGESTION / HEARTBURN		
CHEST PAIN			PEPTIC ULCERS		
HEART DISEASE					
IRREGULAR HEART BEAT			URINATE AT NIGHT >2 TIMES		
HEART MURMUR			LEAKING URINE		
RHEUMATIC FEVER			URINARY TRACT		
SHORTNESS OF BREATH			INFECTIONS		
HIGH CHOLESTEROL			KIDNEY STONES		
HIGH BLOOD PRESSURE			PAINFUL URINATION		
OBESITY			BLOOD IN URINE		
DIABETES					
UNUSUALLY THIRSTY			VENEREAL DISEASE		
SWOLLEN ANKLES			INFERTILITY		
			IMPOTENCE		
GOUT			**FOR FEMALES ONLY**		
VARICOSE VEINS			PAINFUL MENSES / PERIODS		
MAJOR INJURIES			VAGINAL SPOTTING		
ARHTRITIS			BLEEDING AFTER MENOPAUSE		
BROKEN BONES			IRREGULAR MENSES / PERIODS		
JOINT INJURIES			DID YOUR OTHER TAKE A HORMONE		
SCOLIOSIS			(DES) DURING PREGNANCY WITH YOU?		
LEG PAIN WHEN WALKING			DO YOU DO SELF BREAST EXAMS?		
BACK PAIN			METHOD OF BIRTH CONTROL		
			LAST PAP SMEAR NORMAL?		
SLEEPING DIFFICULTY			# OF PREGNANCIES		
MENTAL DISORDER			# OF CHILDBIRTHS		
DEPRESSION			# OF MISCARRIAGES		
NERVOUSNESS			# OF ABORTIONS		
HABITUAL ALCOHOL USE			DATE OF LAST MAMMOGRAM	ABN. ☐	NORMAL ☐
HABITUAL DRUG USE			DATE OF LAST PAP SMEAR	☐	☐

COMMENTS / CURRENT CONDITION

HAVE YOU COMPLETED AN ADVANCED DIRECTIVE OR LIVING WILL ☐ YES ☐ NO

REVIEWED BY: M.D. DATE:

★★★ SEE OTHER SIDE ★★★

MEDIA CITY MEDICAL

MEDIA CITY MEDICAL

HEALTH HISTORY

IDENTIFYING DATA

MEMBER NAME	DATE

INS. PLAN	SS #

SEX	MARITAL STATUS	DATE OF BIRTH

OCCUPATION	PAST OCCUPATION

PRIOR M.D.	DATE OF LAST EXAM

ALLERGIES/REACTIONS TO MEDICATION

1
2
3
4
5
6

MEDICATION: PRESCRIBED AND NON-PRESCRIBED

	DRUG NAME	DOSE	TAKEN HOW OFTEN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CURRENT IMMUNIZATION STATUS

TYPE	APPROX. DATE	HAVE HAD DISEASE
INFLUENZA		
MUMPS		
MEASLES		
RUBELLA / GERMAN MEASLES		
TETANUS		
B.C.G.		
PNEUMONIA VAC.		
HEPATITIS B VAC.		
OTHER		

SURGERIES / PROCEDURES:

	YEAR

ACCIDENTS / INJURIES

SOCIAL

OF CAFFEINE CUPS/DAY

TOBACCO: # PACKS/DAY

STRESS (HIGH, MEDIUM, LOW)

LIFESTYLE/WORK FACTORS THAT INFLUENCE HEALTH

TOXIC OCCUPATIONAL EXPOSURE

DO YOU WEAR SEAT BELTS?

HABITUAL ALCOHOL USE?

HOW MUCH?

HABITUAL DRUG USE?

TYPE & HOW MUCH?

FAMILY HISTORY: (PLEASE INDICATE ANY BLOOD RELATIVE WITH HISTORY OF THE FOLLOWING)

CANCER	STROKE
HIGH CHOLESTEROL	ALZHEIMER S
LEUKEMIA	BLEEDING PROBLEMS
DIABETES	EMPHYSEMA
HIGH BLOOD PRESSURE	ALCOHOLISM
HEART DISEASE	MENTAL ILLNESS
HEART ATTACK	OTHER HEREDITARY DISEASES
SUDDEN DEATH	

★★★ SEE OTHER SIDE ★★★