

Name: _____

Medical History

PERSONAL **MD**

Preventive Care: Enter the date of the most recent test(s)

Colon Cancer Screen	Date	Result
Test for blood in stool (Hemacult)		
Cologuard (DNA test)		
Colonoscopy		
Sigmoidoscopy		
For Men Only		
PSA Blood Test		
For Women Only		
Bone Density Exam		
Pap Smear		
Breast Exam by a Doctor		
Mammogram		
Pap Smear		
HPV Vaccine		
How many times have you been pregnant?		
How many children have you had?		

Genetic Test - have you been screened for either of the following?

Lipoprotein a exam (genetic test for heart)	Yes	No	If Yes: Results
Apo E blood test (genetic test for Alzheimer's)	Yes	No	If Yes: Results

Other

Do You have a living will?	Yes	No
Do You have a Medical Power of Attorney?	Yes	No
Do You have a Do Not Resuscitate (DNR)?	Yes	No

Review of Symptoms (Mark all that apply)

<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	ringing In Ears	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	Ear Pain	<input type="checkbox"/>	Problems with Balance
<input type="checkbox"/>	Swallowing Issues	<input type="checkbox"/>	Joint Swelling
<input type="checkbox"/>	Itchy Eyes	<input type="checkbox"/>	Skin Rash
<input type="checkbox"/>	Visual Changes	<input type="checkbox"/>	Itchy Skin
<input type="checkbox"/>	Eye Redness	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	Chest Tightness	<input type="checkbox"/>	Thinning Hair
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Cough for over 4 weeks	<input type="checkbox"/>	Headaches (more than 4 / month)
<input type="checkbox"/>	Leg Swelling	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	Skipped Heart Beats	<input type="checkbox"/>	Depressed Mood
<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Confusion
<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	Poor Concentration
<input type="checkbox"/>	Rectal Pain	<input type="checkbox"/>	Lack of Interest
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Snoring Problems
<input type="checkbox"/>	Frequent Vomiting	<input type="checkbox"/>	Frequently Tired
<input type="checkbox"/>	Bladder Leakage	<input type="checkbox"/>	Feeling Hopeless
<input type="checkbox"/>	Lumpy Breast	<input type="checkbox"/>	Frequent Urination