ATLANTA CENTER FOR MEDICINE
COMPREHENSIVE PATIENT HISTORY DATABASE

TODAY'S DATE:_____

NAME:_____BIRTH DATE:_____

ADDRESS:_____

TELEPHONE: (HOME)_____(CELL) _____(WORK)_____

EMERGENCY CONTACT:_____PHONE: _____

ALTERNATE PHONE # WHERE DOCTOR CAN LEAVE MESSAGE:_____

WITH WHOM MAY WE DISCUSS YOUR MEDICAL INFORMATION?_____

_____

PHARMACY: _____PHONE:_____

DRUG ALLERGY HISTORY: List all drugs you are allergic to as well as the type of allergic reaction it causes:

NAME OF DRUG	TYPE OF REACTION
_____	_____
_____	_____
_____	_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION NAME	DOSAGE	TIMES TAKEN DAILY

PERSONAL MEDICAL HISTORY

INSTRUCTIONS: Please check or circle any condition that applies to you now, or has applied to you in the past. Include any lab abnormalities or any problem you have taken medication for. Read each section carefully. You may write-in your condition if it is not listed.

CARDIAC

High Blood Pressure
Rheumatic Heart Disease
Anginal Chest Pain
Atrial Fibrillation
Ventricular Tachycardia
Hyperlipidemia
Hypercholesterolemia

Heart Failure
Heart Attack
Heart Murmur
Aortic Stenosis
Mitral Valve Prolapse
Hypertriglyceridemia

Name: _____ **Date:** _____

PULMONARY

Chronic Bronchitis	Emphysema
Tuberculosis	Asthma
Pulmonary Embolism	Pneumonia
COPD	

GASTROINTESTINAL

Irritable Bowel	Ulcerative Colitis
Diverticulitis	Diverticulosis
Gastritis	Liver Cirrhosis
Type B Hepatitis	Crohn's Disease

RENAL

Acute Renal Failure	Kidney Stones
Nephritis	Chronic Kidney Disease
Pyelonephritis	Urinary Tract Infections

SKELETAL AND RHEUMATIC

Arthritis, Fingers	Arthritis, Hand
Arthritis, Shoulder	Arthritis, Neck
Arthritis, Back	Arthritis, Hip
Arthritis, Knee	Arthritis, Ankle
Arthritis, Foot	Arthritis, Toes
Rheumatoid Arthritis	Polymyalgia, Rheumatica
Fibrositis Syndrome	Spondylitis
Spondylosis	Osteoporosis
Back Fracture	Hip Fracture
Wrist Fracture	Humerus Fracture
Tibia-Fibula Fracture	Sciatica
Ruptured Disk	TMJ Syndrome

SKIN

Eczema	Sunburn
Common Warts	Venereal Warts
Acne	Rosacea
Plantar Warts	Malignant Melanoma
Psoriasis	Other Skin Cancer

NEUROLOGICAL

Tension Headaches	Seizures
Epilepsy	Migraine Headaches
Cluster Headaches	TIAs (Small Strokes)
Stroke	Guillian Barre
Syncope (Fainting)	Myasthenia Gravis
Cerebro-Vascular Disease	Deafness

PSYCHIATRIC

Anxiety	Depression
Alzheimer's Disease	Panic Attacks
Anorexia Nervosa	Bulimia
Dementia	Hyperventilation

Name: _____ **Date:** _____

ENDOCRINE

Diabetes (Insulin)	Diabetes (Non-Insulin)
Chronic Cortisone Use	Gout
Hypothyroidism	Hyperthyroidism
Thyroid Goiter	Thyroid Nodule
Hyperparathyroidism	High Blood Calcium

INFECTIOUS DISEASE

Meningitis, Bacterial	Meningitis, Viral
Sinusitis, Acute	Sinusitis, Chronic
Chronic Ear Infection	Cellulitis
Gonorrhea	Syphillis
Herpes, Genital	Fever Blisters
Athletes Foot	Jock Itch
Nail Bed Fungus	Shingles
HIV/AIDS	Pneumocyctic Pneumonia
Hepatitis	

HEMATOLOGIC

Anemia	Chronic Lymphocytic Leukemia
Iron Deficiency	Chronic Myelogenous Leukemia
Lymphoma	Hodgkin's Disease
Lymphadenopathy	Pernicious Anemia

ALLERGY

Hives	Allergic Rhinitis
Hay Fever	Bee Sting
Angioedema	Food

GYNECOLOGICAL, FEMALE URINARY TRACT AND BREASTS

Irregular Menstruation	Amenorrhea
Menopause	Yeast Infections
Pelvic Inflammatory Disease	Ovarian Cyst
Infertility	Vaginitis
Painful Menstruation	Pelvic Pain
Abnormally Heavy Periods	Incontinence
Fibrocystic Breast Disease	

MALE URINARY TRACT

Enlarged Prostate	Acute Prostatitis
Chronic Prostatitis	Urinary Obstruction
Prostrate Nodule	Varicocele
Hydrocele	

CANCER

Skin	Mouth	Tongue
Larynx	Esophagus	Stomach
Colon	Lung	Bladder
Blood	Kidney	Cervical
Breast	Uterine	Rectal
Thyroid	Ovarian	Brain
Lip	Prostate	Salivary Gland

Name: _____ **Date:** _____

PAST SURGICAL HISTORY

Tonsillectomy	Appendectomy	Gallbladder
Hernia	Stomach Ulcer Surgery	Hysterectomy
Ooporectomy	Tubal Ligation	Vasectomy
Hemorrhoids	Heart Valve	Lung
Kidney	Brain	Abdomen
Prostate (TURP)	Bladder	Colon
Back	Coronary Artery Bypass Graft	Breast Biopsy
Mastectomy		

Please list in the space below any surgery you had in the past not listed above:

FAMILY HISTORY

INSTRUCTIONS: Please check or circle the conditions below **found among your family members:**

Hypertension	Heart Disease	Diabetes
Stroke	Atherosclerosis	Kidney Disease
Tuberculosis	Thyroid Disease	Stomach Caner
Colon Cancer	Skin Cancer	Osteoporosis
Arthritis	Breast Cancer	Alcoholism
Malignant Melanoma	High Cholesterol	High Triglycerides
Heart Attacks	Heart Failure	Cancer
Obesity	Depression	Suicide

FAMILY HISTORY

		YEAR OF	Alive?	
Family Member	First Name	BIRTH	Y or N	List their Medical Diseases
Father				
Mother				
Brothers				
Sisters				
Children				

SOCIAL HISTORY

Current occupation_____ Retired? Yes No

Previous occupation if retired_____

Employer_____

Have you ever been exposed to any dangerous fumes, chemicals, cotton dust, or radiation sources? Yes No

Name: _____ **Date:** _____

TOBACCO

Have you used tobacco products? Yes No Never (please circle one)
How many years have (or did) you use tobacco? _____
In what year did you begin to use tobacco? _____
Cigarettes: Packs smoked each day: ½ 1 2 3 4 (please circle one)
Cigars: Number of cigars smoked each day _____
Pipe: Number of ounces of tobacco each week _____
Smokeless tobacco: Ounces used each week_____
If you stopped using tobacco, in what year did you do so? _____

YOUR SEXUAL PREFERENCE:

Heterosexual (straight) Bisexual Homosexual (gay or lesbian) (Please circle one)

DRUGS AND ALCOHOLIC BEVERAGES

Do you now use alcoholic beverages on a regular basis? Yes No Never (Please circle one)
Beer: Number of cans per week _____
Wine: Number of glasses per week: _____
Whiskey/Liquor: Number of ounces consumed weekly _____
In your opinion, do you now or have you ever had a drinking problem Yes No Never (Please circle one)
If you drank alcoholic beverages in the past but no longer consume them, in what year did you stop drinking alcohol? _____
Do you use recreational drugs? Yes No Never (Please circle one)

COMPREHENSIVE REVIEW OF SYSTEMS

INSTRUCTIONS: Please check or circle any symptoms you are **CURRENTLY** experiencing:

GENERAL	Weakness	Fatigue	Lack of Appetite
	Weight Loss	Weight Gain	Chills
	Fever	Insomnia	Night Sweats
SKIN	Rash	Itchiness	Moles
	Warts	Non-healing Ulcers	Acne
	Dryness	Hair Loss	Ring Worm
	Eczema	Abnormal Sweating	
HEAD	Lumps on the Scalp	Headaches	Sore Spots on the Scalp
EYES	Double Vision	Decreased Vision	Burning Eyes
	Cataracts	Pain in the Eyes	Rings around Lights
	Red Eyes	Infected Eyes	
EARS	Decreased Hearing	Ringing in the Ears	Pain in the Ears
	Discharge from the Ears		
NOSE	Nose Bleeds	Stuffy Nose	Constant Runny Nose
	Nasal Obstruction	Broken Nose	Nasal Polyps
	Sinus Infection	Can't Smell	Post Nasal Drip
THROAT	Sore Throats	Strep Throats	Chronic Hoarseness
	Vocal Cord Polyps	Colds Sores on Lips	Mouth Ulcers
	Bleeding Gums	Cavities	Dentures
	Non-Healing Tongue or Mouth Sore		

Name: _____ **Date:** _____

NECK	Chronically Swollen Glands	Neck Pain	Neck Stiffness
	Crick in the Neck	Neck Swelling	

PULMONARY

Breathlessness on Exertion	Breathlessness at Rest	Wake from Sleep Breathless
Cold Air Causes Wheezing	Daily Smokers Cough	Chronic Dry Cough
Daily Coughing of Phlegm	Coughing Up Blood	Pain in Chest with Cough
Exposure to Tuberculosis	Snoring	

BREAST	Breast Lump(s)	Nipple Discharge	Breast Pain
	Breast Cysts		

CARDIAC Chest Pain/Tightness on Physical Exertion

Chest Pain at Rest	Heart Pounding	Heart Racing
Irregular Heart Rate	Ankle Swelling	Leg Pain on Exertion

GASTROINTESTINAL

Nausea	Vomiting	Abdominal Bloating
Indigestion	Lump in the Abdomen	Stomach Cramps
Vomiting Blood	Rectal Bleeding	Black Sticky Stools
Heartburn	Frequent Antacids	Food Allergy
Diarrhea	Constipation	Stomach Burning
Painful Swallowing	Food Sticks on Swallowing	

ENDOCRINOLOGY

Hot Flashes	Cold Intolerance	Heat Intolerance
Frequent Urination	Increased Appetite	Increased Thirst
Weight Loss	Weight Gain	No Sex Interest
Menopause	Loss of Body Hair	Increased Hair Growth

GYNECOLOGIC (WOMEN ONLY)

Age periods began ____	Date of Last Period ____	Vaginal Discharge Yes No
Severe Menstrual Cramps	Pelvic Pain	Are Periods Regular? Yes No
Abnormal Vaginal Bleeding	Painful Intercourse	Decreased Sexual Desire
Vaginal Spotting	Frequent Vaginal Infections	
Vaginal Bleeding After Menopause		

URINARY	Burning on Urination	Frequent Urination	Urinary Retention
	Can't Start Urine Stream	Decreased Urine Stream	Enlarged Prostate
	Genital Ulcers or Blisters	Urinary Tract Infection	Genital Infections
	Can't Hold Urine (Incontinence)	Urine Leakage when you Cough or Sneeze	

NEUROLOGICAL

Headaches	Seizures	
Convulsions	Body Numbness	Body Tingling
Poor Memory	Mental Confusion	Periodic Facial Drooping
Slurring of Words	Arm or Leg Weakness	Blackout Spells
Dizziness	Vertigo	Paralysis of Arm or Leg
Loss of Balance	Difficulty Speaking	

PSYCHIATRIC

Depressed Mood	Crying Spells	Very Nervous/ Anxious
Can't Sleep Well	Personality Change	Hearing Voices
Angry often	Mental Breakdown	I'm thinking about suicide
I've lost interest in things I used to enjoy		

Name: _____ **Date:** _____

Are you aware of the importance of safe sex in the prevention of sexually transmitted diseases? Yes No

Do you always practice safe sex? Yes No Not applicable to my situation

Do you wear seat belts at all times? Yes No

Do you have a smoke detector in your household? Yes No

Do you have a firearm in your household? Yes No If yes, is it locked up? Yes No

Do you exercise regularly? Yes No # of days per week? _____ **If yes,** please list what you do for exercise:_____

VACCINATIONS:

When was your last Tetanus vaccination? _____

When was your last pneumonia vaccination? _____

When was your last Gardasil/HPV vaccination? _____

When was your last shingles vaccination? _____

TESTS:

When was your last cholesterol check? _____

Have you ever had a colonoscopy? Yes No **If yes,** when? _____

Have you ever had a bone density scan (DEXA scan)? Yes No **If yes,** when? _____

FOR INDIVIDUALS BORN 1945 - 1965 <u>ONLY</u>

Have you ever been tested for hepatitis C? Yes No **If yes,** when? _____

FOR MALES <u>ONLY</u>

Are you aware of the importance of testicular self examination? Yes No

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FOR FEMALES <u>ONLY</u>

Approximate date of last PAP smear? _____

Birth Control Method: Abstinence Condoms Birth Control Pills Vasectomy Tubal Ligation Other:___

Last menstrual cycle? Approx Date _____ (or check here if not applicable to your situation ___)

Last mammogram? Approx Date _____ (or check here if you have never had one ___)

Are you aware of the importance of breast self-examination in detection of breast cancer? Yes No

Do you perform monthly self examination of your breasts? Yes No