Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Today's date: _____

HPI Physicians
Medical History Form

Review of Systems

Are you experiencing any of the following symptoms?

General:
- ☐ Chills
- ☐ Excessive Weight Gain/Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness

Skin:
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives
- ☐ Jaundice
- ☐ Rash

HEENT:
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Visual Changes
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Postnasal Drainage
- ☐ Sinus Pressure
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat

Respiratory:
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Difficulty Breathing on Exertion
- ☐ Palpitations
- ☐ Swelling of Extremities

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Groin Pain
- ☐ Incontinence
- ☐ Pelvic Pain
- ☐ Urgency

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Stiffness

Neurologic:
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures
- ☐ Syncope
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble Focusing

Endocrine:
- ☐ Excessive Thirst
- ☐ High Blood Sugar
- ☐ Low Blood Sugar

Hematology:
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Nodes

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Past Medical History

Heart
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Atrial Fibrillation
- ☐ Other_____ _____

Stomach
- ☐ Reflux
- ☐ Heartburn
- ☐ Ulcers
- ☐ Bleeding
- ☐ Irregular Bowel
- ☐ Diverticulitis
- ☐ Liver Disease
- ☐ Hepatic Failure
- ☐ Other_____

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Gestational Diabetes
- ☐ Thyroid
- ☐ Other_____ _____ _____ _____

Lungs
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Other_____ _____

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ Broken Bones
- ☐ Other_____ _____

Neurologic
- ☐ Stroke
- ☐ Headache
- ☐ Migraine
- ☐ Dementia

Dermatology
- ☐ Skin Cancer
- ☐ Acne
- ☐ Rash

Urology
- ☐ Kidney Stones
- ☐ Prostate Issues
- ☐ Other_____

Gynecology
- ☐ Endometriosis
- ☐ HPV

Psychiatric
- ☐ Memory Loss/Confusion
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar

Other
- ☐ Anemia
- ☐ Sinus & Allergy
- ☐ Other_____ _____

- ☐ Cancer: List What Type _____ _____ _____

Social History

Tobacco:
- ☐ Never
- ☐ Current: Cigarettes ☐ Yes ☐ No Amt:_____pck/day How many years have you smoked? _____
  Smokeless Tobacco ☐ Yes ☐ No Amt:_____per day
  Cigars ☐ Yes ☐ No Amt:_____# week
- ☐ Quit: Date last smoked _____ Amt: _____pck/day How many years did you smoke?_____

Children: Secondhand smoke exposure? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No _____# drinks/day

Caffeine use: ☐ Yes ☐ No _____# drinks/day

Seatbelt use: ☐ Yes ☐ No

Exercise: ☐ Yes ☐ No Times per week: _____ Type of exercise: _____

Occupation: _____

Have you ever used **street drugs**: ☐ Yes ☐ No Which ones: ☐ Marijuana ☐ IV drugs ☐ Cocaine ☐ Amphetamines ☐ Heroin ☐ Downers ☐ Inhalants ☐ other _____

Are you still using: ☐ Yes ☐ No Which ones: _____

Are you sexually active (in the last year)? ☐ Yes ☐ No

If yes check all that apply: ☐ 1 Partner ☐ Multiple Partner ☐ Male Partner(s) ☐ Female Partner(s) ☐ 5 or More Partners in your Lifetime

Which birth control do you use? ☐ None ☐ Condoms ☐ The Pill ☐ Vasectomy/Tubal ☐ Other_____

Is there concern for your safety? ☐ Yes ☐ No ☐ Emotional ☐ Physical ☐ Sexual Abuse

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Family History

Have any of your family members had any of the following problems?

☐ Alcoholism	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Asthma	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Breast Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Colon Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Depression	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Elevated Lipids	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Attack	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Lung Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Migraines	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Osteoporosis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Ovarian Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Skin Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Thyroid Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Uterine Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Diagnosis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Other_____

List all **ALLERGIES** to any medications **and** the reactions: ☐ No Known Drug Allergies

Medication	Reaction

IMMUNIZATIONS: **(List Dates)**

Hepatitis A: _____
Hepatitis B: _____
Td- Adult Tetanus Toxoid: _____
Influenza: _____
Pneumovax: _____
PPD – Tuberculin Skin Test (Include Results): _____
Gardasil (HPV): _____
Zostavax: _____

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

CURRENT MEDICATIONS: (Please include over the counter medication and food supplements.)

Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
Drug Name: _____Dose: _____How Often: _____
☐ None

Pregnancy and Birth

Date of Last Menstrual Period: _____ Age of First Period: _____
# of Days In Flow: _____ # of Days Between Cycles: _____
Are you Menopausal ☐ Yes ☐ No Age at Onset Of Menopause: _____
# of Pregnancies: _____ # of Live Births: _____ # of Abortions _____# of Miscarriages _____
# of Living Children _____

Past Surgical History

Please check or list all of the SURGERIES you have had:

Type of Surgery	Year
☐Appendectomy	
☐Arthroscopy (joint)	
☐ Back Surgery or ☐ Neck Surgery	
☐Cataract Surgery	
☐Cesarean Section	
☐Gallbladder Removal	
☐Heart Surgery (Specify)	
☐Hemorrhoids	
☐Hernia (Specify)	
☐Hysterectomy	
☐ Knee Replacement or ☐ Hip Replacement	
☐Mastectomy or Lumpectomy (Specify)	
☐Polyp Removal (Colon)	
☐Tonsillectomy or ☐ Adenoidectomy	
☐Tubal Ligation or ☐ Vasectomy	
☐Plastic Surgery (Specify)	
☐Other (Specify)	
☐Other (Specify)	
☐Other (Specify)	

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Have you had any orthopedic complaints resulting in radiology procedures in the last year?
(ex: Xray, MRI, CT scan)

Radiology Procedure	Year

Health Maintenance

Date of last Mammogram: _____ Date of last Bone Density: _____
Date of last Colonoscopy: _____
(Diabetic Patients) Date of last Eye Exam:_____ Where: _____
FOR WOMEN: Date of last Pap Smear: _____
FOR MEN: Date of Last PSA level drawn (Prostate Cancer Screening):_____

Please provide **first & last** names of all other physicians that you currently see and their specialty:

_____
_____

What is your preferred pharmacy (Please include name and phone number): _____
_____

What is your preferred mail order pharmacy (Please include name and phone number): _____
_____