VINEYARD MEDICAL CARE – MEDICAL HISTORY FORM

DATE: _____ NAME: _____ DOB: _____

REASON FOR VISIT: _____

ALLERGIES: _____

PREFERRED PHARMACY: _____

CURRENT MEDICATIONS, INCLUDING VITAMINS AND SUPPLEMENTS:	DOSE:	HOW OFTEN:

PAST AND PRESENT MEDICAL CONDITIONS (CIRCLE ALL THAT APPLY):

ADHD	CANCER	HEART ATTACK	LIVER DISEASE	SUBSTANCE ABUSE
ANEMIA	CHEST PAIN/ANGINA	HEART DISEASE	MENTAL ILLNESS	THYROID DISORDER
ANXIETY	DEPRESSION	HEARTBURN/GERD	OVERWEIGHT/OBESITY	OTHER:
ARTHRITIS	DIABETES TYPE:	HEPATITIS A B OR C	OSTEOPOROSIS	
ASTHMA	DEMENTIA	HIGH CHOLESTEROL	PNEUMONIA	
BLOOD DISORDER	GLAUCOMA	HIGH BLOOD PRESSURE	PROSTATE DISORDER	
BOWEL DISEASE	GOUT	IMPAIRED VISION	SEIZURES	
BRONCHITIS	HEARING IMPAIRMENT	KIDNEY DISEASE	STROKE	

PAST SURGICAL PROCEDURES/BLOOD TRANSFUSIONS:	DATE:	PAST SURGICAL PROC./TRANSF. CONT.	DATE:

LIST ANY SIGNIFICANT HEALTH PROBLEMS OF IMMEDIATE FAMILY MEMBERS:

MOTHER:		SIBLINGS:	
FATHER:		CHILDREN:	

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

DO YOU EXERCISE? RARELY OCCASIONALLY REGULARLY NEVER

SEXUALLY ACTIVE? YES NO

CURRENTLY EMPLOYED? YES NO DISABLED RETIRED

OCCUPATION: _____ NUMBER OF HOURS PER WEEK: _____

	YES	NO	QUIT (INDICATE WHEN)	AMOUNT PER DAY
DO YOU USE TOBACCO?				
DO YOU DRINK ALCOHOL?				
DO YOU DRINK CAFFEINE?				
DO YOU USE ANY RECREATIONAL DRUGS?				

PATIENT SIGNATURE: _____DATE: _____

PLEASE REVIEW CURRENT SYMPTOMS ON OTHER SIDE OF THIS SHEET

VINEYARD MEDICAL CARE – REVIEW OF SYSTEMS CHECKLIST

General-
- □ Weight loss or gain
- □ Fatigue
- □ Fever or chills
- □ Weakness
- □ Trouble sleeping

Skin-
- □ Rashes
- □ Lumps
- □ Itching
- □ Dryness
- □ Color changes
- □ Hair and nail changes

Head-
- □ Headache
- □ Head Injury
- □ Neck Pain

Ears-
- □ Decreased hearing
- □ Ringing in ears
- □ Earache
- □ Drainage

Eyes-
- □ Vision Loss/Changes
- □ Glasses or contacts
- □ Pain
- □ Redness
- □ Blurry or double vision
- □ Flashing lights
- □ Specks
- □ Glaucoma
- □ Cataracts

Nose-
- □ Stuffiness
- □ Discharge
- □ Itching
- □ Hay fever
- □ Nosebleeds
- □ Sinus pain

Throat-
- □ Sore tongue
- □ Dry mouth
- □ Sore throat
- □ Hoarseness
- □ Thrush
- □ Non-healing sores

Neck-
- □ Lumps
- □ Swollen glands
- □ Pain
- □ Stiffness

Breasts-
- □ Lumps
- □ Pain
- □ Discharge
- □ Breast-feeding

Respiratory-
- □ Cough
- □ Sputum
- □ Coughing up blood
- □ Shortness of breath
- □ Wheezing
- □ Painful breathing

Cardiovascular-
- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations
- □ Shortness of breath with activity
- □ Difficulty breathing while lying down
- □ Swelling
- □ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
- □ Swallowing difficulties
- □ Heartburn
- □ Change in appetite
- □ Nausea
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea
- □ Yellow eyes or skin

Urinary-
- □ Frequency
- □ Urgency
- □ Burning or pain
- □ Blood in urine
- □ Incontinence
- □ Change in urinary strength

Vascular-
- □ Calf pain with walking
- □ Leg cramping

Musculoskeletal-
- □ Muscle or joint pain
- □ Stiffness
- □ Back pain
- □ Redness of joints
- □ Trauma

Neurologic-
- □ Dizziness
- □ Faint
- □ Seizure
- □ Weakness
- □ Numb
- □ Tingling
- □ Tremor

Hematologic-
- □ Ease of bruising
- □ Ease of bleeding

Endocrine-
- □ Heat or cold intolerance
- □ Sweating
- □ Frequent urination
- □ Thirst
- □ Change in appetite

Psychiatric-
- □ Nervousness
- □ Stress
- □ Depression
- □ Memory loss