HagathaMED

Comprehensive Medical History

Medical History

Prior Hospitalizations (attach additional sheets if necessary):

Name:		Date:	
Date of hospitalization	**Reason for hospitalization**	**Name of hospital**	**Name of doctor**

Prior Surgeries (attach additional sheets if necessary):

Date of surgery	Reason for surgery	Name of hospital	Name of doctor

Have you ever had any of the following?	Yes	No
Polyp or tumor removed from the colon or	☐	☐
Tuberculosis or positive skin test (PPD)?	☐	☐
Blood transfusions or other blood products?	☐	☐
Positive HIV test or AIDS?	☐	☐
Cancer? If yes, specify type.	☐	☐
Sexually transmitted disease (STD)?	☐	☐
Cardiac stress test or other cardiac testing?	☐	☐
Heart attack or other heart problem?	☐	☐
Abnormal liver enzymes or liver disease?	☐	☐
Kidney disease or hemodialysis?	☐	☐
Thyroid disease or thyroid surgery?	☐	☐
Diabetes mellitus?	☐	☐
High blood pressure (hypertension)?	☐	☐
Lung disease such as asthma, bronchitis or other?	☐	☐
Stroke or other bran disorders?	☐	☐
Mental disease or psychiatric evaluation?	☐	☐
Specify other major illnesses that you have had:		

Female Patients Only:		Yes	No
Date of last menstrual period:	Are you regular?	☐	☐
If irregular, how often?:	Describe your bleeding:		
How long does your menses regularly last:			
Last Pap Smear	Month: Year:		
Have you ever had an abnormal Pap Smear?		☐	☐
Have you ever experienced menopause or had a hysterectomy?		☐	☐
Have you ever had an abnormal mammogram?		☐	☐
Have you ever had an ectopic pregnancy?		☐	☐
No. of pregnancies?	Live Births? Miscarriages/Abortions?		

Male Patients Only:	Yes	No
Have you ever had abnormal prostate examination or PSA?	☐	☐
Have you ever had an abnormal testicular examination?	☐	☐

Family History	Current age/ age of death:	Medical problems:
Father		
Mother		
Paternal grandfather		
Paternal grandmother		
Maternal grandfather		
Maternal grandmother		
Brothers and sisters		
Others (specify)		

Any family history of:	Yes	No		Yes	No
Cancer	☐	☐	Lung disease	☐	☐
Heart attack	☐	☐	Stroke	☐	☐
High blood pressure	☐	☐	Mental disorders	☐	☐
Diabetes	☐	☐	Alcohol abuse	☐	☐
Kidney disease	☐	☐	Neurologic disease	☐	☐
Liver disease	☐	☐	i.e Parkinson's		

Life Style Assessment:	Yes	No	If you answered yes to eating fast food or/and eating out regularly, please
Eating Habits			**Indicate how often and preferred fast food or dine-in restaurants here:**
A. I eat fast-food regularly. If yes, indicate frequency below	☐	☐	
B. I eat out regularly	☐	☐	
C. I skip meals regularly	☐	☐	
D. I eat three meals a day and snack	☐	☐	
E. I snack throughout the day	☐	☐	**Exercise Habits: How often per week, duration and type of activity**
F. I eat vegetables regularly	☐	☐	
G. I eat meat (beef, pork, chicken) regularly	☐	☐	
H. I drink soda, iced tea, gatorade or other sugary drinks regularly	☐	☐	
I. I drink unflavored water regularly	☐	☐	

Social History

Marital Status: ☐Single ☐Married ☐ Divorced ☐Widowed

Employer:_____

Highest educational level attained:

☐ less than High School ☐High School ☐Some college

☐ Graduated college ☐Advanced degree ☐ Professional degree

Do you or have you used any nicotine products? If yes, what type _____

How much per day? _____

What year did you start using Tobacco? _____

When did you quit? _____

Alcohol usage: _____

Street drugs: _____

Religious beliefs relevant to med. care? ☐Yes ☐No

Do you have a living will? ☐Yes ☐No

Social Assessment:	Yes	No
A. Are you presently experiencing an *unusually* stressful situation?	☐	☐
B. Have you ever felt a need to cut down on your alcohol consumption?	☐	☐
C. Do relatives or friends worry or complain about your alcohol consumption?	☐	☐
D. Are you being physically, emotionally or sexually abused?	☐	☐
E. Do you feel you may have a drug problem?	☐	☐

Self Care Assessment:

Do you have a difficulty performing these activities by yourself?

	Yes	No		Yes	No
A. Eating	☐	☐	D. Bathing	☐	☐
B. Dressing	☐	☐	E. Walking	☐	☐
C. Using Toilet	☐	☐	F. Housekeeping	☐	☐

HagatñaMED

Annual General Medical Examination Information

Name:	DOB:	Age:	Date of Visit:
Current medical concerns *(subjective)*:			

Current Medications (medicines, vitamins, supplements, etc.)	Dosage?	How often?	Since when?
Allergies?			

***Review of systems: Indicate symptoms you are experiencing now or within the past week.**

General:	☐ Fever	☐ Chills	☐ Appetite problems	☐ Weight change	☐ Night sweats	☐ Other
Skin:	☐ Rash	☐ Skin lump	☐ Sore	☐ Change in mole	☐ Skin infection	☐ Unusual itching ☐ Other
Head:	☐ Head Trauma	☐ Frequent Headaches	☐ Other			
Eyes:	☐ Vision change	☐ Double vision	☐ Glasses or lens	☐ Cataracts	☐ Glaucoma	☐ Itchy, watery eyes ☐ Other
Ears:	☐ Hearing change	☐ Ringing	☐ Infection	☐ Pain	☐ Discharge	☐ Dizziness ☐ Other
Nose/Sinus:	☐ Sinus pain	☐ Congestion	☐ Runny nose	☐ Allergy symptoms	☐ Other	
Mouth/Throat:	☐ Sore throat	☐ Mouth sores	☐ Dentures	☐ Swollen tonsils	☐ Other	Last dental exam?
Breasts:	☐ Breast pain	☐ Nipple Discharge		☐ Breast lump	☐ Other	
	Do you do self breasts exams?	☐ Yes	☐ No	Last mammogram:		
Respiratory:	☐ Dry cough	☐ Coughing out blood		☐ Wheeze	☐ Short of breath	☐ Chest congestion
	☐ Coughing out phlegm	☐ Other				
Heart:	☐ Chest pain	☐ Murmur	☐ Irregular heart beat	☐ Chest pressure	☐ Palpitations	☐ High blood pressure
	☐ Leg swelling	☐ Difficulty sleeping flat on your back		☐ Other		
Stomach:	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Hemorrhoids	☐ Heart burn/reflux (GERD)
	☐ Black or dark stools		☐ Blood in stools	☐ Abdominal pain	☐ Bloating/gas	☐ Other
Genitalia:	☐ Discharge	☐ Genital pain	☐ Impotence	☐ Genital itching	☐ Genital lump	☐ Genital lump
	☐ Pain with intercourse		**FEMALES ONLY**	☐ Menstrual problems	Last pap smear:	Last menstrual period:
Urinary:	☐ Painful urination	☐ Incontinence	☐ Frequent urination	☐ Blood in urine	☐ Night urination	☐ Difficulty stating a stream
	☐ Leaking urine	☐ Kidney stone	☐ Incomplete emptying			
Muscles/bones and joints:	Back injury	☐ Gout	☐ Morning stiffness	☐ Back pain	☐ Joint swelling	☐ Other
Neurologic:	☐ Seizures	☐ Stroke	☐ Slurred speech	☐ Memory problems	☐ Confusion	☐ Loss of consciousness ☐ Other
Psychiatric:	☐ Depression	☐ Anxiety	☐ Psychiatric care	☐ Hallucinations	☐ Nervousness	☐ Suicidal thoughts
	☐ Obsessive compulsive behavior		☐ Other			
Endocrine:	☐ Excessive thirst	☐ Cold intolerance	☐ Heat intolerance	☐ Excessive urination	☐ Other	
Hematologic:	☐ Easy bruising	☐ Blood clots	☐ Excessive bleeding			