MEDICAL HISTORY CHECK-LIST

PREPARED FOR: | By: | Date:
---|---|---

Have you ever had:

- Scarlet Fever: YES \(\text{or} \ NO\)
- Meningitis: YES \(\text{or} \ NO\)
- Infectious Mononucleosis: YES \(\text{or} \ NO\)
- Tuberculosis: YES \(\text{or} \ NO\)
- Exposure to TB: YES \(\text{or} \ NO\)
- Malaria: YES \(\text{or} \ NO\)
- Bronchitis: YES \(\text{or} \ NO\)
- Pneumonia: YES \(\text{or} \ NO\)
- Pleurisy: YES \(\text{or} \ NO\)
- Hepatitis (yellow jaundice): YES \(\text{or} \ NO\)
- Bladder infections: YES \(\text{or} \ NO\)
- Rheumatic fever: YES \(\text{or} \ NO\)
- Kidney disease: YES \(\text{or} \ NO\)
- Hives: YES \(\text{or} \ NO\)
- Hay fever/sinusitis: YES \(\text{or} \ NO\)

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- Hives: YES \(\text{or} \ NO\)
- Hay fever/sinusitis: YES \(\text{or} \ NO\)

FAMILY HISTORY

Has any blood relative had any of the following:

- Anemia: YES \(\text{or} \ NO\)
- Leukemia: YES \(\text{or} \ NO\)
- Repeated infections: YES \(\text{or} \ NO\)
- Crippling arthritis: YES \(\text{or} \ NO\)
- Chronic lung disease: YES \(\text{or} \ NO\)
- High blood pressure: YES \(\text{or} \ NO\)
- Kidney disease: YES \(\text{or} \ NO\)
- Asthma: YES \(\text{or} \ NO\)
- Severe allergies: YES \(\text{or} \ NO\)
- Mental illness: YES \(\text{or} \ NO\)
- Convulsions or seizures: YES \(\text{or} \ NO\)

If yes, what relationship:

Anemia: YES \(\text{or} \ NO\)

Leukemia: YES \(\text{or} \ NO\)

Recurrent infections: YES \(\text{or} \ NO\)

Crippling arthritis: YES \(\text{or} \ NO\)

Chronic lung disease: YES \(\text{or} \ NO\)

High blood pressure: YES \(\text{or} \ NO\)

Kidney disease: YES \(\text{or} \ NO\)

Asthma: YES \(\text{or} \ NO\)

Severe allergies: YES \(\text{or} \ NO\)

Mental illness: YES \(\text{or} \ NO\)

Convulsions or seizures: YES \(\text{or} \ NO\)

Migraine headaches: YES \(\text{or} \ NO\)

Diabetes: YES \(\text{or} \ NO\)

Gout: YES \(\text{or} \ NO\)

Obesity: YES \(\text{or} \ NO\)

Thyroid trouble: YES \(\text{or} \ NO\)

Peptic ulcer: YES \(\text{or} \ NO\)

Chronic diarrhea: YES \(\text{or} \ NO\)

Cancer: YES \(\text{or} \ NO\)

Suicide: YES \(\text{or} \ NO\)

Gallbladder Disease: YES \(\text{or} \ NO\)

Alcoholism: YES \(\text{or} \ NO\)

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MEDICAL HISTORY CHECK-LIST

OPERATIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>C Section</td>
<td></td>
<td></td>
<td>Thyroid</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Tonsils</td>
<td>YES</td>
<td>NO</td>
<td>Varicose Veins</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Gall Blander</td>
<td>YES</td>
<td>NO</td>
<td>Hemorrhoids</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Breast</td>
<td>YES</td>
<td>NO</td>
<td>Heart</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Uterus and/or Ovary</td>
<td>YES</td>
<td>NO</td>
<td>Kidney Stones</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Prostate</td>
<td>YES</td>
<td>NO</td>
<td>Other</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hernia</td>
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<td>NO</td>
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INJURIES

<table>
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<tr>
<th>Body Part</th>
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</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
<td></td>
<td>Broken bones</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Chest</td>
<td>YES</td>
<td>NO</td>
<td>Back</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Abdomen</td>
<td>YES</td>
<td>NO</td>
<td>Other</td>
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</tbody>
</table>

ALLERGIES

Are you allergic to:

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
<th>Other drugs: please list:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foods</td>
<td>YES</td>
<td>NO</td>
<td>Penicillin</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Cosmetics</td>
<td>YES</td>
<td>NO</td>
<td>Sulfa</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Tetanus antitoxin</td>
<td>YES</td>
<td>NO</td>
<td>Other drugs: please list:</td>
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<td>NO</td>
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</table>

IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>YES</th>
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<th>Vaccine</th>
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</thead>
<tbody>
<tr>
<td>Tetanus shot</td>
<td></td>
<td></td>
<td>Flu shot</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Polio oral</td>
<td>YES</td>
<td>NO</td>
<td>Others(list)</td>
<td>YES</td>
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</tr>
</tbody>
</table>

GENERAL

Have you had a lot of any of these symptoms now or in the last six months?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Tire easily weakness</td>
<td>YES</td>
<td>NO</td>
<td>Sensitivity to heat</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Market weight change</td>
<td>YES</td>
<td>NO</td>
<td>Sensitivity to cold</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Night sweats</td>
<td>YES</td>
<td>NO</td>
<td>Hernia</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Persistent fever</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SKIN

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eruptions (rash)</td>
<td>YES</td>
<td>NO</td>
<td>Changes in hair</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Change in color</td>
<td>YES</td>
<td>NO</td>
<td>Changes in nails</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
# MEDICAL HISTORY CHECK-LIST

## EYES
- Trouble seeing Eye pain
  - YES
  - NO
- Eye pain
  - YES
  - NO
- Inflamed eyes
  - YES
  - NO
- Double vision
  - YES
  - NO
- Worn glasses
  - YES
  - NO

## EARS
- Loss of hearing
  - YES
  - NO
- Ringing in ears
  - YES
  - NO

## NOSE
- Loss of smell
  - YES
  - NO
- Frequent colds
  - YES
  - NO
- Obstruction
  - YES
  - NO
- Excess discharge
  - YES
  - NO
- Nosebleeds
  - YES
  - NO

## MOUTH
- Sore gums
  - YES
  - NO
- Soreness of tongue
  - YES
  - NO
- Dental problems
  - YES
  - NO

## THROAT
- Post nasal drainage
  - YES
  - NO
- Soreness
  - YES
  - NO
- Hoarseness
  - YES
  - NO

## BREASTS
- Lumps
  - YES
  - NO
- Discharge
  - YES
  - NO

## CARDIO-RESPIRATORY SYSTEM
- Cough persisting
  - YES
  - NO
- Difficult breathing lying down
  - YES
  - NO
- Sputum (phlegm)
  - YES
  - NO
- Swelling of ankles
  - YES
  - NO
- Bloody sputum
  - YES
  - NO
- Bluish fingers or lips
  - YES
  - NO
- Wheezing
  - YES
  - NO
- High blood pressure
  - YES
  - NO
- Chest pain or discomfort
  - YES
  - NO
- Palpitations
  - YES
  - NO
- Pain on breathing
  - YES
  - NO
- Vein trouble
  - YES
  - NO
- Shortness of breath
  - YES
  - NO
- Other
  - YES
  - NO
## GASTRO-INTESTINAL

**Symptoms now or in the last six months?**

- **Change in appetite**: YES | NO  
- **Difficulty swallowing**: YES | NO  
- **Heartburn**: YES | NO  
- **Abdominal distress**: YES | NO  
- **Belching or excess gas**: YES | NO  
- **Abdominal enlargement**: YES | NO  
- **Nausea**: YES | NO  
- **Vomiting**: YES | NO  
- **Vomiting of blood**: YES | NO  
- **Rectal bleeding**: YES | NO  
- **Tarry stools**: YES | NO  
- **Jaundice**: YES | NO  
- **Constipation**: YES | NO  
- **Hemorrhoids**: YES | NO  
- **Need for laxatives**: YES | NO  
- **Change in appetite**: YES | NO  
- **Difficulty swallowing**: YES | NO  
- **Heartburn**: YES | NO  
- **Abdominal distress**: YES | NO  
- **Belching or excess gas**: YES | NO  
- **Abdominal enlargement**: YES | NO  
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- **Tarry stools**: YES | NO  
- **Jaundice**: YES | NO  
- **Constipation**: YES | NO  
- **Hemorrhoids**: YES | NO  
- **Need for laxatives**: YES | NO  

## GENITOURINARY SYSTEM

- **Increase in urination frequency (day)**: YES | NO  
- **Increase in urination frequency (night)**: YES | NO  
- **Feel need to urinate without much urine**: YES | NO  
- **Unable to hold urine**: YES | NO  
- **Pain or burning**: YES | NO  
- **Blood in urine**: YES | NO  
- **Lack of sex drive**: YES | NO  

## ENDOCRINE

- **Thyroid trouble**: YES | NO  
- **Adrenal trouble**: YES | NO  
- **Cortisone treatment**: YES | NO  
- **Diabetes**: YES | NO  

## LOCOMOTOR

- **Muscle cramps**: YES | NO  
- **Muscle weakness**: YES | NO  
- **Swollen joints**: YES | NO  
- **Stiffness**: YES | NO  
- **Deformity of joints**: YES | NO  
- **Pain in joints**: YES | NO  

## NERVOUS SYSTEM

- **Headache**: YES | NO  
- **Dizziness**: YES | NO  
- **Fainting**: YES | NO  
- **Convulsions or fits**: YES | NO  
- **Nervousness**: YES | NO  
- **Sleeplessness**: YES | NO  
- **Depression**: YES | NO  
- **Change in sensation**: YES | NO  
- **Memory loss**: YES | NO  
- **Poor coordination**: YES | NO  
- **Weakness or paralysis of muscles**: YES | NO  

## OBSTETRICS-GYNECOLOGY

- **Started menstruating at age**: _____  
- **Duration**: _____ days_____  
- **Date of last period**: _____/_____/_____  
- **Flow**: light | normal | heavy |  
- **Pain with periods**: yes | no |  
- **Interval between periods**: _____  
- **Duration**: _____ days_____  

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