Name

DOB

Date

Garrett Medical Group, P.A.

Occupation _____ Age _____ Marital Status Single Married Widowed Divorced

Birth Place _____ Education _____ years High School _____ years College

FAMILY HISTORY		If Living		If Deceased		Has any blood	Yes or No?		
		Age	Health	Age at death	Cause	relative ever had	(Circle)		Who
Father						Cancer	Y	N	
Mother						Tuberculosis	Y	N	
Brother or Sister	1.					Diabetes	Y	N	
	2.					Heart Trouble	Y	N	
	3.					High blood pressure	Y	N	
	4.					Stroke	Y	N	
	5.					Epilepsy	Y	N	
Husband or Wife						Insanity	Y	N	
Son or Daughter	1.					Suicide	Y	N	
	2.								
	3.								
	4.								
	5.								
	6.								

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

PERSONAL HISTORY

ILLNESSES: Have you ever had		
Measles	No	Yes
German Measles	No	Yes
Mumps	No	Yes
Chicken Pox	No	Yes
Whooping Cough	No	Yes
Scarlet Fever or Scarlentina	No	Yes
Diphtheria	No	Yes
Smallpox	No	Yes
Rheumatic fever or heart disease	No	Yes
Polio or Meningitis	No	Yes
Gonorrhea or Syphilis	No	Yes
Tuberculosis	No	Yes
ALLERGIES: Are you allergic to		
Penicillin or Sulfa	No	Yes
Aspirin, Codeine or Morphine	No	Yes
Mycins or other Antibiotics	No	Yes
Merthiolate or Mercurochrome	No	Yes
Any other drug	No	Yes
Any foods	No	Yes
Adhesive tape	No	Yes
Nail polish or other cosmetics	No	Yes
Tetanus Antitoxin or Serums	No	Yes
SURGERY: Have you had		
Tonsillectomy	No	Yes
Appendectomy	No	Yes
Any other operation	No	Yes
Type _____ Year _____	No	Yes
Type _____ Year _____	No	Yes
Type _____ Year _____	No	Yes
Have you ever been advised to have any surgical operation which has not been done	No	Yes

Have you been hospitalized for any illness	No	Yes
Give Details:		

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL: Do you		
Smoke _____ packs per day		
Pipe _____ _____ years		
Cigars _____ _____ quit		
Use alcohol	No	Yes
How much _____		
Exercise regularly	No	Yes
Feel tired or rundown	No	Yes
Have problems sleeping	No	Yes
Have you ever had a blood transfusion	No	Yes
SKIN:		
Any skin problems	No	Yes
Itching or burning	No	Yes
Rash	No	Yes
Eczema or hives	No	Yes
Varicose veins	No	Yes
Change in hair	No	Yes
Problems with toe or fingernails	No	Yes

NEUROLOGIC: Have you ever		
Fainted or been knocked out	No	Yes
Had numbness or tingling of arms, legs or one side of body	No	Yes
Had seizures or convulsions	No	Yes
Had a tremor	No	Yes
Been depressed	No	Yes
Been treated for mental illness	No	Yes
Had unusual mood swings	No	Yes
Had a stroke	No	Yes
Had a warning of a stroke or TIA	No	Yes
HEAD:		
Do you have headaches	No	Yes
Have you ever been injured in the head	No	Yes
EYES:		
Do you		
Wear glasses or contacts	No	Yes
Have pain in the eyes	No	Yes
Blurry vision	No	Yes
Double vision	No	Yes
Have glaucoma	No	Yes
Have cataracts	No	Yes
Have flashing lights in front of eyes or black spots	No	Yes
Have momentary or temporary blindness	No	Yes
Have eye pain	No	Yes
Name of eye doctor _____		
Date last checked _____		

Name

DOB

Date

Garrett Medical Group, P.A.

EARS: Do you have
Pain in ears No Yes
Ringing, roaring or tinnitus No Yes
Discharge No Yes
Infections No Yes
Hearing problems No Yes
Balance problems No Yes
NOSE: Do you have
Sinus problems No Yes
Nose Bleeds No Yes
Loss of smell No Yes
Hay fever No Yes
MOUTH: Do you have
Dentures No Yes
Sores in mouth No Yes
White spots in mouth No Yes
Name of dentist _____
NECK: Do you have
Unusual lumps or bumps No Yes
Arthritis No Yes
Goiter or thyroid problems No Yes
BLOOD: Do you
Bruise easily No Yes
Have bleeding problems No Yes
Have anemia or low blood No Yes
Any blood diseases No Yes
RESPIRATORY: Have you ever
Had bronchitis or pneumonia No Yes
Had wheezing, asthma, hayfever No Yes
Coughed up blood No Yes
Been told you have emphysema No Yes
Worked around
Asbestos No Yes
Silica dust and sand No Yes
Coal dust No Yes
Toxic chemicals No Yes
Had a chest x-ray No Yes
When _____
Had pleurisy No Yes
Had night sweats No Yes
Have a chronic cough No Yes
Cough up phlegm No Yes
Do you get short of breath No Yes
When _____
_____
CARDIAC: Do you have
High blood pressure No Yes
Any heart problems No Yes
A heart murmur No Yes
Chest pain, tightness
or discomfort No Yes
Palpitations or skip beats No Yes
Swelling of hands or feet No Yes
Do you wake up at night
short of breath No Yes
Use more than 1 pillow No Yes
Get out of breath going uphill No Yes
Up stairs No Yes
On level ground No Yes
Do you have angina No Yes
Have you ever been told you had
a heart attack No Yes
Do you get leg cramps No Yes
GASTROINTESTINAL:
Appetite ( ) good ( ) poor
Do you have or have ever had
a change in weight No Yes
trouble swallowing No Yes
heartburn or indigestion No Yes
ulcers No Yes
hepatitis or yellow jaundice No Yes
Problem with nausea and
vomiting No Yes
Problems with fried food or
fatty food No Yes
Gall bladder problems No Yes
Any problems with bowel
movement No Yes
How often do bowels move _____
Use laxatives No Yes
Bleeding in bowels No Yes
Vomiting blood No Yes
Hemorrhoids No Yes
Problems with diarrhea No Yes
GENITOURINARY: Have you ever had
Bladder or kidney infections No Yes
Passed blood No Yes
Passed a stone No Yes
Lose control of urine with cough,
sneeze, exercise No Yes
Do you get up at nights
to urinate No Yes
How often _____
ENDOCRINE: Do you have
Excess thirst or urination No Yes
Inability to withstand heat or
cold No Yes
Change in texture of hair No Yes
Dry skin No Yes
Any diabetes in family No Yes
Any thyroid problems or goiter
in family No Yes
MUSCULOSKELETAL:
Any broken bones No Yes
Which bones _____
_____
_____
Arthritis No Yes
Which joints _____
_____
_____
Do your joints get red, hot,
swollen No Yes
Any back pain or problems No Yes
MEN ONLY: Do you have
Prostate problems No Yes
Weak or slow urine No Yes
Burning or discharge from penis No Yes
Swelling or lumps in testicles No Yes
Hernia or rupture No Yes
Difficulty getting or maintaining
an erection No Yes
WOMEN ONLY:
Age when periods started _____
period stopped _____
Date of last period _____
Date of last Pap Smear _____
Periods: Regular ( ) irregular ( )
Unusually painful ( ) Heavy ( )
Any vaginal bleeding between
periods No Yes
Vaginal discharge No Yes
Pain in pelvis No Yes
Do you now use or did you ever use
IUD No Yes
Birth control pills No Yes
Pregnancies:
How many _____
How many stillbirths _____
How many premature _____
How many miscarriages _____
Any complications No Yes
Do you have:
Breast lumps No Yes
Breast pain No Yes
Breast discharge No Yes
Any relative with breast cancer No Yes

COMMENTS _____