Broadway
MEDICAL CLINIC

DATE ____________

PATIENT NAME	BIRTHDATE	MRN#

PAST MEDICAL HISTORY

Have you ever had the following? (Check "no" or "yes" and leave blank if uncertain)

	No	Yes		No	Yes		No	Yes		No	Yes
Measles	☐	☐	Anemia	☐	☐	Back trouble	☐	☐	Hepatitis	☐	☐
Mumps	☐	☐	Bladder infections	☐	☐	High blood pressure	☐	☐	Ulcer	☐	☐
Chickenpox	☐	☐	Epilepsy	☐	☐	Low blood pressure	☐	☐	Kidney disease	☐	☐
Whooping cough	☐	☐	Migraines headaches	☐	☐	Hemorrhoids	☐	☐	Thyroid disease	☐	☐
Scarlet Fever	☐	☐	Tuberculosis	☐	☐	Date of last chest xray	____		Bleeding tendency	☐	☐
Diptheria	☐	☐	Diabetes	☐	☐	Ashtma	☐	☐	Any other disease	☐	☐
Smallpox	☐	☐	Cancer	☐	☐	Hives or eczema	☐	☐	(please list)		
Pnuemonia	☐	☐	Polio	☐	☐	AIDS or HIV+	☐	☐	____________		
Rheumatic fever	☐	☐	Glaucoma	☐	☐	Infectious mono	☐	☐	____________		
Heart disease	☐	☐	Hernia	☐	☐	Bronchitis	☐	☐	____________		
Arthritis	☐	☐	Blood or plasma			Mitral valvle prolapse	☐	☐	____________		
Venereal disease	☐	☐	transfusions	☐	☐	Stroke	☐	☐	____________		

Previous Hospitalizations/Surgeries/Serious Illness	When?	Hospital, City, State

History of skin reaction other adverse reaction to:

	No	Yes		No	Yes
Penicillin or other antibiotics	☐	☐	Morhpine, Demerol, or other narcotics	☐	☐
Novocain or other anesthetics	☐	☐	Aspirin or other pain remedies	☐	☐
Tetanus antitoxin or other serumes	☐	☐	Iodine, Mertholate, or other antiseptic	☐	☐

Other drugs/medications: ____________

Known food allergies: ____________

Environmental allergies: ____________

Medications (include non-prescription): ____________

PATIENT/SOCIAL HISTORY

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco ☐ Never ☐ Previously, but quit ☐ Chew

Use of drugs ☐ Never ☐ Type/frequency ____________

Excessive exposure at work or home to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne particles ☐ Noise

FAMILY MEDICAL HISTORY

	Age	Disease	If Deceased, Cause of Death
Mother			
Father			
Siblings			
Spouse			
Children			

REVIEW OF SYSTEMS

Please indicate any personal history below:

Constitutional Systems:	No	Yes
Good general health lately	☐	☐
Recent weight change	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Headaches	☐	☐

Eyes:	No	Yes
Eye disease or injury	☐	☐
Wear glasses/contact lenses	☐	☐
Blurred or double vision	☐	☐

Ears/Nose/Mouth/Throat:	No	Yes
Hearing loss or ringing	☐	☐
Earaches or drainange	☐	☐
Chronic sinusitis or rhinitis	☐	☐
Nose bleeds	☐	☐
Mouth sores	☐	☐
Bleeding gums	☐	☐
Bad breath or bad taste	☐	☐
Sore throat or voice change	☐	☐
Swollen glands in neck	☐	☐

Cardiovascular:	No	Yes
Heart trouble	☐	☐
Chest pain or angina pectoris	☐	☐
Palpitations	☐	☐
Shortness of breath w/walking	☐	☐
or lying flat		
Swelling of feet, ankles, or hands	☐	☐

Respiratory:	No	Yes
Chronic fatigue and frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal:	No	Yes
Loss of appetite	☐	☐
Change in bowel movements	☐	☐
Nausea of vomitting	☐	☐
Frequent diarrhea	☐	☐
Painful bowel movements or constipation	☐	☐
Rectal bleeding or blood in stool	☐	☐
Abdominal pain	☐	☐

Genitourinary:	No	Yes
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Change in force of strain when urintating	☐	☐
Incontinence or dribbling	☐	☐
Kidney stones	☐	☐
Sexual difficulty	☐	☐
Male-testicle pain	☐	☐
Female-pain with periods	☐	☐
Female- irregular periods	☐	☐
Female-vaginal discharge	☐	☐
Female-# of pregnancies	______	
Female-# of miscarriages	______	
Female-date of last pap smear	______	

Muscoloskeletal:	No	Yes
Joint pain	☐	☐
Joint stiffness or swelling	☐	☐
Weakness of muscles or joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Cold extremities	☐	☐
Difficulty in walking	☐	☐

Integumentary (skin, breast):	No	Yes
Rash or itching	☐	☐
Change in skin color	☐	☐
Change in hair or nails	☐	☐
Varicose veins	☐	☐
Breast pain	☐	☐
Breast lump	☐	☐
Breast discharge	☐	☐

Neurological:	No	Yes
Frequent or recurring headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsions or seizures	☐	☐
Numbness or tingling sensations	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Head injury	☐	☐

Psychiatric:	No	Yes
Memory loss or confusion	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Insomnia	☐	☐

Endocrine:	No	Yes
Glandular or hormone problem	☐	☐
Excessive thirst or urination	☐	☐
Heat of cold intolerance	☐	☐
Skin becoming dryer	☐	☐
Change in hat or glove size	☐	☐

Hematologic/Lymphatic:	No	Yes
Slow to heal after cuts	☐	☐
bleeding or bruising tendency	☐	☐
Anemia	☐	☐
Phlebitis	☐	☐
Past transfusion	☐	☐
Enlarged glands	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to preform the necessary services I need.

X ______________________________ ______________

Signature of Patient **Date**

DOCTOR'S REVIEW

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X ______________________________ ______________

Signature of Doctor **Date**