Drs. Combs and Lutz, L.L.C. -- Patient Medical History Form

				/ /
LAST NAME	FIRST NAME	MIDDLE NAME	TITLE	D.O.B. (MM/DD/YYYY)
EMERGENCY CONTACT NAME		RELATION TO PATIENT		PHONE #

OTHER DOCTORS I HAVE SEEN

ALLERGIES

MEDICATIONS (Prescription & Over the Counter Medicine) INCLUDE NAME, DOSAGE & FREQUENCY	

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS & PRIOR SURGERIES
Have you ever donated blood ☐ Yes ☐ No Date of last blood donation:

ALCOHOL / TOBACCO / DRUG RISK SCREEN	
1. Do you use cigarettes, pipes, cigars or chew tobacco?	☐ Yes ☐ No
2. Do you drink alcohol? If YES, answer questions below.	☐ Yes ☐ No
- Ever tried to cut back on the amount of alcohol you drink?	☐ Yes ☐ No
- Ever become angry when people discuss your consumption?	☐ Yes ☐ No
- Ever feel guilty about anything you did because of your drinking?	☐ Yes ☐ No
- Ever had a drink before noon (eye opener)?	☐ Yes ☐ No
- Has your drinking affected your relationship with your family or friends?	☐ Yes ☐ No
- Has your drinking affected your work or school?	☐ Yes ☐ No
- Have you ever drunk alcohol while or before driving or driven while intoxicated?	☐ Yes ☐ No
3. Do you drink more than 3 cups of coffee, sodas or other caffeinated beverages daily?	☐ Yes ☐ No
4. Are you currently using any street drugs or prescription drugs belong to another person?	☐ Yes ☐ No

SOCIAL HISTORY
Do you think that you are at risk for HIV, AIDS or other sexually transmitted diseases? ☐ Yes ☐ No
Have you ever been tested for HIV? ☐ Yes ☐ No If YES, when?
What was the result of the test?
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated ☐ Other
Education: ☐ Jr. High School ☐ High School/GED ☐ Vocational School ☐ College ☐ Other
Occupation: Do you have a Living Will? ☐ Yes ☐ No Want information about one? ☐ Yes ☐ No

FAMILY HISTORY – FAMILY MEMBERS				
Family Member	Age		Medical Problems	Cause of Death
☐ Father		☐ Alive ☐ Deceased		
☐ Mother		☐ Alive ☐ Deceased		
☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
☐ Brother ☐ Sister		☐ Alive ☐ Deceased		

FAMILY HISTORY - DISEASES			
1. Alzheimer's Disease	☐ Yes ☐ No _____	11. Iron Storage Disease	☐ Yes ☐ No _____
2. Depression	☐ Yes ☐ No _____	12. Anemia	☐ Yes ☐ No _____
3. Suicide	☐ Yes ☐ No _____	13. Breast Cancer	☐ Yes ☐ No _____
4. Substance Abuse	☐ Yes ☐ No _____	14. Ovarian Cancer	☐ Yes ☐ No _____
5. Heart Disease	☐ Yes ☐ No _____	15. Prostate Cancer	☐ Yes ☐ No _____
6. Stroke	☐ Yes ☐ No _____	16. Skin Cancer	☐ Yes ☐ No _____
7. High Blood Pressure	☐ Yes ☐ No _____	17. Sickle Cell Disease	☐ Yes ☐ No _____
8. High Cholesterol	☐ Yes ☐ No _____	18. Thyroid Disease	☐ Yes ☐ No _____
9. Obesity	☐ Yes ☐ No _____	19. Macular Degeneration	☐ Yes ☐ No _____
10. Diabetes	☐ Yes ☐ No _____	20. Other:	

HEALTH MAINTENANCE	(Please indicate YEAR for all items or enter "None".)		
1. TESTS	2. WOMEN	3. IMMUNIZATIONS	
Last Blood Tests:	Last PAP Smear:	Tetanus:	Influenza:
Last Colonoscopy:	Last Mammogram:	Pneumonia:	Hepatitis A or B:

Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

CONSTITUTIONAL		SKIN		MUSCULAR SKELETAL	
Unexplained weight loss	☐ Yes ☐ No	Skin changes	☐ Yes ☐ No	Neck pain	☐ Yes ☐ No
Unexplained weight gain	☐ Yes ☐ No	Skin lesions	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Fevers	☐ Yes ☐ No	Skin itching	☐ Yes ☐ No	Injury to limbs	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Rashes	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Dry skin	☐ Yes ☐ No	Joint stiffness	☐ Yes ☐ No
Nausea or Vomiting	☐ Yes ☐ No	**GASTROINTESTINAL**		Locking joints	☐ Yes ☐ No
EYES		Blood in stool	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Glasses	☐ Yes ☐ No	Change in movements	☐ Yes ☐ No	Red or swollen joints	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	**HEMATOLOGY/ONCOLOGY**	
Change in vision Glasses	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Anemia or low blood	☐ Yes ☐ No
Red eyes	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	Easily bruise	☐ Yes ☐ No
HEAD		Heart burn	☐ Yes ☐ No	Swollen lymph nodes	☐ Yes ☐ No
Bleeding from gums	☐ Yes ☐ No	Hemorrhoids	☐ Yes ☐ No	Cancers	☐ Yes ☐ No
Problems hearing	☐ Yes ☐ No	Black tarry stool	☐ Yes ☐ No	**PSYCHIATRIC**	
Change in your voice	☐ Yes ☐ No	Nausea or vomiting	☐ Yes ☐ No	Depression or sadness	☐ Yes ☐ No
Denture	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No	Feel like hurting someone	☐ Yes ☐ No
Nose bleeds	☐ Yes ☐ No	**GENITOURINARY**		Feel like hurting yourself	☐ Yes ☐ No
Hoarse voice	☐ Yes ☐ No	Problems urinating	☐ Yes ☐ No	Problems with memory	☐ Yes ☐ No
Sinus problems	☐ Yes ☐ No	Blood in urine	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Ringing in ears	☐ Yes ☐ No	Hernias	☐ Yes ☐ No	Problems concentrating	☐ Yes ☐ No
Mouth ulcers	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Problems sleeping	☐ Yes ☐ No
CARDIOVASCULAR		Urination at night	☐ Yes ☐ No	**NEUROLOGY**	
Angina	☐ Yes ☐ No	Sexual transmitted disease	☐ Yes ☐ No	Change in memory	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Urinary urgency	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	**WOMEN ONLY**		Headaches	☐ Yes ☐ No
Leg pain with walking	☐ Yes ☐ No	Problems with your period	☐ Yes ☐ No	Imbalance	☐ Yes ☐ No
Problems with exercise	☐ Yes ☐ No	Vaginal dryness	☐ Yes ☐ No	Numbness	☐ Yes ☐ No
Swelling in legs	☐ Yes ☐ No	Problems with sex	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Problems lying flat	☐ Yes ☐ No	Vaginal discharge	☐ Yes ☐ No	Tremors	☐ Yes ☐ No
Skipping heart beats	☐ Yes ☐ No	Pain in breast	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Short of breath at night	☐ Yes ☐ No	Lumps in breast	☐ Yes ☐ No	**ENDOCRINE**	
RESPIRATORY		Breast discharge	☐ Yes ☐ No	Problems with heat	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	**MEN ONLY**		Problems with cold	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Problems with erections	☐ Yes ☐ No	Swelling in neck	☐ Yes ☐ No
Coughing up blood	☐ Yes ☐ No	Dribbling of urine	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Weak urine stream	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Pain in testicles	☐ Yes ☐ No	Changes in hair	☐ Yes ☐ No

_____ _____

PATIENT'S SIGNATURE DATE