

MED-ASSIST DOCTORS' GROUP

Medical Profile

DATE

PATIENT NAME IN FULL

M
 F

AGE

MEDICAL RECORD NUMBER

DATE OF BIRTH

MARITAL STATUS

OCCUPATION

PERSONAL AND FAMILY HISTORY

• Indicate if you or anyone in your family has (or has ever had) any of the following conditions.
• If a member of your family has had one of these conditions, indicate their relationship to you.

DESCRIPTION	PERSONAL		FAMILY		RELATION	DESCRIPTION	PERSONAL		FAMILY		RELATION
	YES	NO	YES	NO			YES	NO	YES	NO	
Hearing problems						High cholesterol					
Heart disease / circulatory problems						Epilepsy or seizures					
High blood pressure						Migraine headaches					
Stroke						Arthritis or Gout					
Asthma, emphysema, bronchitis						Depression / nervous problem					
Ulcers / Digestive problems						Diabetes					
Drug / Alcohol problems						Hepatitis or liver problems					
Cancer: Breast						Thyroid disease					
Colon						Sleep apnea					
Prostate						Anemia / Blood disease					
Other, where?						HIV / AIDS / STDs					
Kidney stones / Cysts / Failure						Tuberculosis					
Gallbladder						Osteoporosis					

SOCIAL HISTORY

INDICATE USAGE

Tobacco No Yes PACKS OR CANS PER DAY FOR HOW MANY YEARS DATE QUIT

Alcoholic Beverages No Yes HOW MANY DRINKS PER WEEK HOW MANY DRINKS PER MONTH

Caffeinated Beverages No Yes CUPS OF COFFEE PER DAY POP / TEA PER DAY

TOTAL NUMBER OF CHILDREN IN HOME **Childbirth History** # OF PREGNANCIES # MISCARRIAGES OR LOST PREGNANCIES ANY COMPLICATIONS OF PREGNANCY

Are you afraid of anyone at home? No Yes Do you have guns at home? No Yes Are they locked up? No Yes

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TESTS

HOSPITALIZATION/ SURGERY / DIAGNOSTIC TEST	DATE	HOSPITALIZATION/ SURGERY / DIAGNOSTIC TEST	DATE

LIST ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS WITH DOSES YOU ARE CURRENTLY USING

MEDICATION NAME / DOSE	MEDICATION NAME / DOSE	MEDICATION NAME / DOSE

ARE YOU ALLERGIC TO ANY MEDICATIONS

No Yes - List

IMMUNIZATIONS

TYPE OF IMMUNIZATION	DATE	OTHER IMMUNIZATIONS	DATE
Last Pneumonia			
Last Tetanus			
Last Influenza			
Last TB Skin Test			

If under 18, are immunizations current No Yes

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REVIEW OF SYSTEMS

Review the list below. Check each item to show if you now have or have recently had any of these problems. (Yes, No or Occasionally)
If you need help with this form our staff will be happy to assist you.

Y N O CONSTITUTIONAL

- Fatigue
- Fever
- Chills
- Sweats
- Night Sweats
- Weight Change

Y N O EYES

- Glaucoma
- Cataracts
- Corrective eyeglasses or lenses
- Recent visual change

Date of last eye exam

Y N O ENT

- Allergic Rhinitis
- Frequent sore throats
- Recent hearing change
- Hearing aids
- Ringing in your ears
- Dentures
- Sores in mouth

Y N O RESPIRATORY

- Frequent cough
- Cough up sputum or phlegm
- Cough up blood
- Short of breath at rest
- Short of breath with exertion
- Wheezing
- Excessive snoring

Date of last chest X-ray

Y N O CARDIOVASCULAR

- Chest tightness, pressure or pain
- Swelling in your feet or legs
- Sleep on more than one pillow
- Awaken at night unable to get your breath
- Pounding heart beats (Palpitations)
- Rapid heart rates for no reason
- Light headedness
- History of a heart murmur
- Leg cramps when walking

Y N O GASTROINTESTINAL

- Frequent heartburn or indigestion
- Frequent nausea
- Frequent or recurrent vomiting
- Vomiting blood
- Frequent or recurrent diarrhea
- Constipation
- Hemorrhoids
- Blood in stool
- Black stool
- Use laxatives frequently

Date of last colon exam

Y N O GENITOURINARY

- Painful urination
- Get out of bed at night to urinate

How many times

- History of kidney stones

Y N O MEN ONLY

- Difficulty with erection
- Dribbling of urine
- Decreased urine stream size
- Difficulty starting urination

Y N O WOMEN ONLY

- History of breast lumps or Breast tissue changes
- Nipple discharge
- Change in periods
- Hot flashes
- Hormonal medications
- Method of birth control (if applicable)

Date of last Mammogram

Date of last Pap Smear

Date of last period

Name of Gynecologist

Y N O MUSCULOSKELETAL

- Joint Pains
- Joint Swelling
- Frequent backaches

Y N O NEUROLOGIC

- History of seizures
- History of fainting (syncope)
- History of temporary paralysis
- History of stroke (CVA)
- Frequent headaches

Y N O PSYCHIATRIC

- Depression
- Anxiety
- Crying spells
- Change in personality

Y N O SKIN (INTEGUMENTARY)

- Skin lesions or change in moles
- Skin Rash

Y N O HEMATOLOGIC / LYMPHATIC

- Easy bruising
- History of anemia
- History of blood transfusion
- Swollen lymph glands

Y N O ENDOCRINE

- History of thyroid problems
- Difficulty tolerating heat or cold
- Recent change in skin or hair

Y N O ALLERGIC / IMMUNOLOGICAL

- History of hives
- Frequent pneumonia
- Removal of spleen
- Use of Prednisone or steroids

UPDATE TO MEDICAL PROFILE / ROS - FOR CLINIC USE ONLY

DATE	PHYSICIAN	INITIALS	DATE	PHYSICIAN	INITIALS