Patient Reported Medical History

GRAYED AREAS ARE FOR SITE STAFF USE ONLY

PERSONAL INFORMATION

Name: ________________________ DOB: ________________ Birth Sex: M F

Gender: M F Other

LIFESTYLE

Nicotine	No	Yes	If yes: ______# Packs per day for ________ years.	Start date:_______	Stop date:_______
Alcohol	No	Yes	If yes: ______# Drinks per day for ________ years.	Start date:_______	Stop date:_______
Recreational Drug Use	No	Yes	If yes: ______# _____ per day for ________ years.	Start date:_______	Stop date:_______
Exercise	No	Yes, if yes:_______# of times per week.		Start date:_______	

FAMILY HISTORY

Relationship	Illnesses	Age at Death	Cause of Death
Father			
Mother			
Siblings: M F			
Siblings: M F			

MEDICATIONS

Medication	Indication	Frequency	Strength /Dose	Method	Start Date	Stop Date
Example: Simvastatin	High cholesterol	1 x/day	20mg	Pill, drops, spray	5/2001	7/2011-OR-C*

ALLERGIES

Medication/Product	Describe Reaction	Year	NCS

HOSPITALIZATIONS, SURGERIES & PROCEDURES

Description	Reason	Year	NCS

IMMUNIZATION HISTORY

Vaccine	Date Completed	Vaccine	Date Completed
Hepatitis B (Hep B) Series Completed		Pneumococcal (PCV, PPSV) Series Completed	
Rotavirus (RV1, RV5) Series Completed		Polio (IPV, OPV) Series Completed	
Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT) Series Completed		Measures, Mumps, Rubella (MMR) Series Completed	
Tetanus, Diphtheria (Td) Completed		Varicella (chickenpox) Series Completed	
Haemophilus influenzae type b (Hib) Completed		Hepatitis A (Hep A) Series Completed	
Influenza (flu) most recent		Human Papillomavirus (HPV) Series Completed	
Meningococcal (MCV, MPSV) Series Completed		Other:	

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	ALLERGIES	Start Year	End Year	NCS
	Seasonal Allergies/Hay Fever			
	Food Allergies			
	Other:			

	EYES, EARS, NOSE, THROAT	Start Year	End Year	NCS
	Nose Bleeds			
	Farsighted/Nearsighted			
	Glaucoma			
	Tinnitus [Ringing in Ears]			
	Retinopathy			
	Chronic Ear Infections			
	Sinus Infections			
	Glasses/Contacts			
	Trouble Swallowing			
	Hoarseness			
	Cataracts			
	Hearing Loss			
	Macular Degeneration			
	Meniere's Disease			
	Nasal/Sinus Congestion			
	Other:			

	RESPIRATORY/CHEST	Start Year	End Year	NCS
	Tuberculosis			
	Asthma			
	COPD/Emphysema/Chronic Bronchitis			
	Sleep Apnea			
	Sarcoidosis			
	Pulmonary Hypertension			
	Shortness of Breath			
	Pneumonia			
	Lung Cancer			
	Pulmonary Fibrosis/ Interstitial Lung Disease			
	Other:			

	DERMATOLOGICAL	Start Year	End Year	NCS
	Skin Cancer			
	Rosacea			
	Eczema			
	Cold Sores			
	Acne			
	Psoriasis			
	Actinic Keratosis			
	Hives			
	Other:			

	ENDOCRINE/METABOLIC	Start Year	End Year	NCS
	Diabetes			
	High Cholesterol			
	High Triglycerides			
	Thyroid Disease/Nodule			
	Other:			

Check all that Apply

	NEUROLOGICAL	Start Year	End Year	NCS
	Headaches [Tension/Stress]			
	Memory Loss			
	Alzheimer's			
	Fainting			
	Lightheadedness			
	Vertigo [Dizziness]			
	Numbness/tingling			
	Migraine Headaches w/o Aura			
	Migraine Headaches w/ Aura			
	Unsteady Gait			
	Seizure Disorder/Epilepsy			
	Frequent Falls			
	Insomnia			
	Paralysis			
	Tremors			
	Multiple Sclerosis (MS)			
	Diabetic/Other Neuropathy			
	Parkinson's Disease			
	Shingles			
	Restless Leg Syndrome			
	CTA/TIA			
	Stroke			
	Other:			

	CARDIOVASCULAR	Start Year	End Year	NCS
	Chest Pain (Angina)			
	Chest Discomfort			
	Arrhythmia [Irregular Heartbeat]			
	High Blood Pressure [Hypertension]			
	Heart Attack			
	Enlarged Heart			
	Peripheral Vascular Disease			
	Heart Murmur			
	Abnormal ECG			
	Carotid Disease			
	Congestive Heart Failure			
	Edema [Swelling of Feet]			
	Aortic Aneurysm			
	Coronary Artery Disease			
	Mitral Valve Prolapse			
	Venous Thrombosis [Clots] /Phlebitis			
	Other:			

	PSYCHATRIC	Start Year	End Year	NCS
	Depression			
	ADHD/ADD			
	Bipolar			
	Anxiety			
	OCD			
	Panic Disorder			
	Other:			

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	GASTROINTESTINAL/HEPATIC	Start Year	End Year	NCS
	Heartburn			
	Indigestion			
	Frequent Constipation			
	Ulcers			
	Gastroparesis			
	Hemorrhoids			
	Hepatitis			
	Chronic Abdominal Pain			
	Lactose Intolerance			
	GI Bleed			
	Crohn's/Ulcerative Colitis			
	Acid Reflux/GERD			
	Bloody Stool			
	Frequent Diarrhea			
	Irritable Bowel Syndrome			
	Diverticulitis/Diverticulosis			
	Dark/Black Stool			
	Gallbladder Disease			
	Chronic Vomiting			
	Hernias			
	Gallstone			
	Pancreatitis			
	NASH/Fatty Liver Disease			
	Other:			
	Last colonoscopy:			

	GENITOURINARY	Start Year	End Year	NCS
	Urinary Incontinence [Leaking Urine]			
	Painful Urination			
	Frequent Nighttime Urination			
	Kidney Stones			
	Bladder Infection			
	Sexually Transmitted Disease			
	Hematuria [Blood in Urine]			
	Kidney Disease			
	Overactive Bladder			
	Kidney Infection			
	Chronic Urinary Tract Infections			
	Decreased Libido			
	Other:			

Check all that Apply

	MUSCULOSKELETAL	Start Year	End Year	NCS
	Neck Pain			
	Osteoarthritis			
	Arthritis			
	Broken Bones/Fractures			
	Fibromyalgia			
	Herniated Disc			
	Back Pain			
	Osteoporosis/Osteopenia			
	Rheumatoid Arthritis			
	Carpal Tunnel			
	Tendinitis			
	Gout			
	Strains/Sprains			
	Recurrent Joint Pain			
	Other:			

	BLOOD (HEMATOLOGIC/LYMPHATIC)	Start Year	End Year	NCS
	Swollen Glands			
	Blood Clotting Disorders			
	Easy Bruising			
	Anemia			
	Frequent Blood/Plasma Donor			
	Other:			

	MALES ONLY	Start Year	End Year	NCS
	Prostate Issues (BPH, enlarged)			
	Erectile Dysfunction			
	Vasectomy			
	Other:			

	FEMALES ONLY	Start Year	End Year	NCS
	Hot Flashes			
	Irregular Periods			
	Sexual Difficulties			
	Last Mammogram Date:			
	Last Pap Smear Date:			
	Hysterectomy			
	Tubal Ligation			
	Pregnancy History #:			
	Last Menstrual Period – Month/Year:			
	Other Gynecological Conditions			
	Specify:			

	CANCER (MALIGNANCIES)	Start Year	End Year	NCS

Study Participant's Signature:
(Upon Completion or updating of form, sign & date next available line)

Completed by: ________________________ Date: ____________

Completed by: ________________________ Date: ____________

Completed by: ________________________ Date: ____________

Site Staff's Signature:
(Upon Completion or updating of form, sign & date next available line)

Completed by: ________________________ Date: ____________

Completed by: ________________________ Date: ____________

Completed by: ________________________ Date: ____________

Physician Investigator's Signature:

Reviewed by: ________________________ Date: ____________

Reviewed by: ________________________ Date: ____________

Reviewed by: ________________________ Date: ____________