Atchison Hospital Clinics Date____________________

PATIENT MEDICAL HISTORY

Name_______________________________________ Date of Birth________________

Medications: Please include prescription, over the counter, non-prescription, and herbal preparations.

Medications	Dose	How Often Taken

Allergies & Adverse Reactions

Medication	Type of Reaction

Vaccinations: Please indicate the last date you received each immunization.

Flu________________________ Pneumonia______________________ TDAP______________________

Past Procedure & Surgical History

Procedure	Date	Where Performed
Ear/Nose/Throat Surgeries		
Heart Testing (Cath, Echo, or Stress)		
Open Heart Surgery		
Tubal Ligation		
Pap Smear		
Mammogram		
EGD (Scope looking into stomach)		
Colonoscopy (Scope looking into colon)		
Joint Surgery or Joint Replacement		
Other		

Family History: Place an "X" in the appropriate boxes to identify all illnesses/conditions in your blood relatives.

	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
High Blood Pressure								
High Cholesterol								
Heart Disease								
Diabetes								
Liver Disease								
Colon or Rectal Cancer								
Other Cancer (Specify Type)								
Alcohol/Drug Abuse								
Depression								
Other								

Past Medical History: Place an "X" in the appropriate boxes and provide a date of diagnosis if possible.

Eyes, Ears, Nose, Throat
- ☐ Glasses or Contacts
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Seasonal Allergies
- ☐ Other___________________

Neurologic
- ☐ Stroke/TIA
- ☐ Dizziness
- ☐ Seizure Disorder
- ☐ Headaches
- ☐ Other___________________

Pulmonary/Lungs
- ☐ Asthma
- ☐ Chronic Cough
- ☐ COPD
- ☐ Pneumonia
- ☐ Other___________________

Cardiovascular
- ☐ Aneurysm
- ☐ Irregular Heartbeat
- ☐ Heart Attack or Heart Disease
- ☐ Leg Swelling
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Peripheral Vascular Disease
- ☐ Blood Clot In Extremity
- ☐ Other___________________

Gastrointestinal
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Diverticulitis/Diverticulosis
- ☐ Hemorrhoids
- ☐ Heartburn/Reflux (GERD)
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis A, B, or C
- ☐ Other___________________

Genitourinary
- ☐ Chronic Kidney Disease
- ☐ Urinary Incontinence/ Frequency/Retention
- ☐ Urinary Tract Infection
- ☐ BPH/Enlarged Prostate
- ☐ Abnormal Pap Smear
- ☐ Ovarian Cysts
- ☐ Pelvic Pain
- ☐ Other__________________

Muscle/Joint/Bone
- ☐ Chronic Pain Site_____________________
- ☐ Fibromyalgia
- ☐ Fracture Site_____________________
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other____________________

Endocrine
- ☐ Diabetes
- ☐ Hyperthyroid/Hypothyroid
- ☐ Other___________________

Skin
- ☐ Acne
- ☐ Eczema
- ☐ Rosacea
- ☐ Other________________

Psychiatric
- ☐ General Anxiety Disorder
- ☐ Depression
- ☐ Bipolar
- ☐ Insomnia
- ☐ ADD/ADHD
- ☐ Other________________

Cancer
- ☐ Please Specify Type_________________

Please list any specialists you are seeing____