YO SAN UNIVERSITY CLINIC

PATIENT MEDICAL HISTORY

Please fill in ALL PAGES BEFORE YOUR APPOINTMENT. Your answers will help us plan and provide your care. Leave blank any parts you are unsure of, or do not wish to answer. Any information provided will be kept confidential.

PRESENTING PROBLEM:

The purpose of your visit today is: ____

____

CURRENT MEDICAL HISTORY

Do you have **allergies**? ☐ Yes ☐ No ☐ Not Sure / Don't know

If so, please list: ____

Do you wear a cardiac pacemaker? ☐ Yes ☐ No ☐ Not Sure / Don't know

Occupation: ____

Do you have a regular exercise program? ☐ Yes ☐ No
If so, please describe: ____

Do you have any dietary restrictions? ☐ Yes ☐ No
If so, please describe: ____

Please describe your average daily diet:

Morning: ____

Afternoon: ____

Evening: ____

Do you smoke? ☐ Yes ☐ No, never smoked ☐ No, I have quit smoking
If yes, how many packs of cigarettes do you smoke a day? ______________________

How much coffee, tea, or caffeinated beverage do you consume?
☐ 1-2 cups per day ☐ 2-5 cups per day ☐ >5 cups per day ☐ occasional/social ☐ None

How much alcohol do you consume per week?
☐ 1-2 drinks per day ☐ 2-5 drinks per day ☐ >5 drinks per day ☐ occasional/social ☐ None

Please describe any use of drugs for non-medical purposes: ______________________

____

Patient Name: ______________________________

CURRENT MEDICATIONS

Please list all the medications you are currently taking, including all vitamins and supplements

Name of medication	Purpose	Frequency / Dose

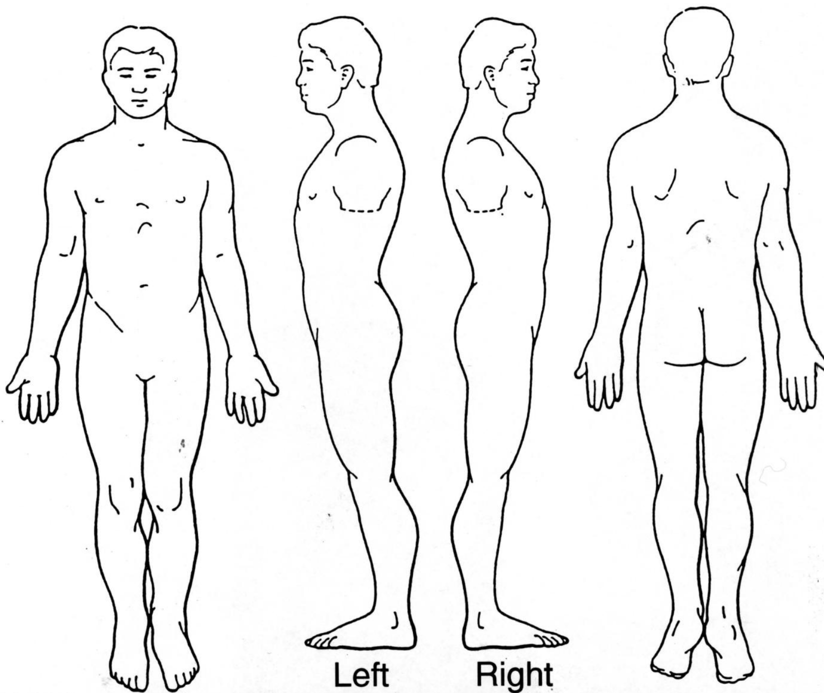
PAIN:

Are you currently in pain? ☐ Yes ☐ No

If YES, please describe: ____

____

Please indicate affected and/or painful area(s)



Worst Possible Pain
(Dolor severo)

10
9
8
7
6
5
4
3
2
1
0

Moderate Pain
(Dolor moderado)

No Pain
(No dolor)

Pain	
x	Little
xx	Moderate
xxx	strong

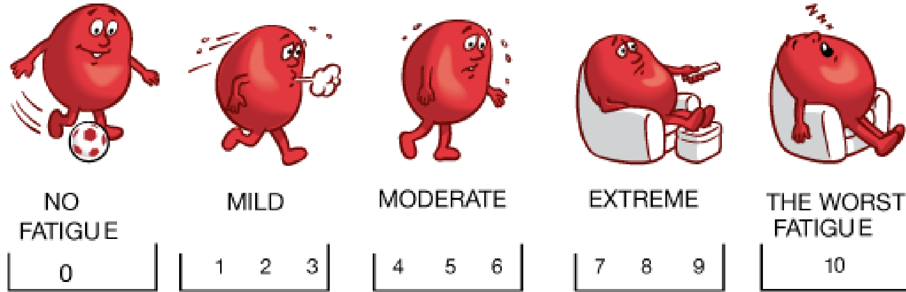
Patient Name: ______________________________

FATIGUE:

Do you feel fatigued? ☐ Yes ☐ No

If YES, please describe: ____

____



Women only:

Are you pregnant now? ☐ Yes ☐ No

Number of pregnancies:__________________ Number of children:________________

Age of first period:________________ Age of menopause:________________

Is your menstrual cycle regular? ☐ Yes ☐ No ☐ Post-menopausal

1. Average number of days in flow:________
2. Volume: ☐ Normal ☐ Heavy ☐ Light
3. Color: ☐ Normal ☐ Dark red ☐ Purple ☐ Light brown
4. Do you have the following menstruation related signs/symptoms?
   - ☐ Blood clots ☐ Cramps ☐ Nausea ☐ Breast distension
   - ☐ Mood changes ☐ Bleeding/spotting between periods
   - ☐ Heavy vaginal discharge between periods

Do you use any contraception? ☐ Yes ☐ No ☐ Not applicable

If Yes, please describe:____

Libido (sex drive) is: ☐ Low ☐ Normal ☐ High

Men Only

Do you experience any of the following? (*please check all that applies)*

☐ Feeling coldness or numbness in the external genitalia ☐ Pain or swelling in testicles

☐ Premature ejaculation ☐ Impotence/ erectile dysfunction

Libido (sex drive) is: ☐ Low ☐ Normal ☐ High

Patient Name: ________________________________

FAMILY MEDICAL HISTORY

Does any member of your family (parents & siblings) have any of the following?

Diabetes	Hypertension	Cardiovascular Diseases	Autoimmune diseases
Cancer	Stroke	Seizures	

If so, please describe:____

____

REVIEW OF SYSTEMS

Please check all the symptom(s) that you are currently experiencing:

Constitutional Symptoms
- ☐ Fatigue / low energy
- ☐ Poor appetite
- ☐ Insomnia / poor sleep
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Heat sensation or hot flashes
- ☐ Unexplained weight loss or gain

Allergy/Immunological
- ☐ Hay Fever

Ear / Nose / Throat / Oral
- ☐ Ear Infection
- ☐ Hearing loss
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Oral (canker) sores
- ☐ Bleeding, swollen painful gums
- ☐ Halithosis (bad breath)

Eyes / Vision
- ☐ Blurred / double vision
- ☐ Eye pain
- ☐ Dryness / irritation

Gastrointestinal
- ☐ Heart burn / Reflux
- ☐ Nausea / vomiting
- ☐ Abdominal pain / cramps
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bleeding from rectum
- ☐ Black sticky stools
- ☐ Hemorrhoids
- ☐ Change in bowel habits

Respiratory
- ☐ Chronic cough
- ☐ Chest congestion
- ☐ Shortness of breath
- ☐ Recurrent chest infection
- ☐ Asthma / wheezing

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Edema / swelling

Neurological
- ☐ Headaches
- ☐ Dizziness / fainting
- ☐ Numbness / tingling sensations
- ☐ Tremors
- ☐ Seizures / epilepsy

Musculoskeletal
- ☐ Joint pain / stiffness / swelling
- ☐ Neck pain / stiffness
- ☐ Back pain / stiffness
- ☐ Muscle weakness

Endocrine
- ☐ Excessive thirst
- ☐ Feeling too hot / too cold
- ☐ Elevated blood sugar / diabetes
- ☐ Elevated blood cholesterol / lipids

Urinary
- ☐ Blood in urine
- ☐ Bladder / kidney infection
- ☐ Problem with urination
- ☐ Bladder / kidney stones

Hematological
- ☐ Easy bruising
- ☐ Swollen glands
- ☐ Excessive bleeding
- ☐ Blood clotting problems

Skin / Dermatological
- ☐ Skin rash
- ☐ Persistent itch

Psychological
- ☐ Feeling sad or depressed
- ☐ Worried / anxious

Patient Name: ________________________________