IU Health Physicians

History | Physical
Progress | Other

Patient Label

Patient/MD/Provider Checklist for Medical History

Except for space reserved "For MD/Provider Use Only," we request each patient fill out this from and **return it to your physician/care provider on the first visit.**

Today's Date	Social Security #	Date of Birth	Age

☐ In-Patient ☐ Out-Patient

PATIENT'S LEGAL NAME: *(Last, First, Middle Initial, Nickname)*

Address *(Street, Apt. #) — Where patient lives.* City, State Zip

Home Phone #	Work Phone #	Cell #	Email Address

Do you have a **Living Will** or **Advance Directive**? ☐ Yes ☐ No

My Primary Care Physician Is:

Physician's Name _____

Address _____

City, State _____ Zip _____

Phone _____ FAX _____

Email _____

Other Providers Who Should Receive Medical Information from Us:

1. Name _____
   Address _____
   City, State _____ Zip _____
   Phone _____ FAX _____
2. Name _____
   Address _____
   City, State _____ Zip _____
   Phone _____ FAX _____

REVIEW OF SYSTEMS

Please check yes or no to indicate if you have any of the following symptoms. If there are question you prefer not to answer, leave them blank, and you may discuss them with the physician or provider.

GENERAL	YES	NO		YES	NO
Fevers	☐	☐	Feeling Too Cold	☐	☐
Night Sweats	☐	☐	Normal Weight for You _____ lbs		
Enlarged Lymph Nodes	☐	☐	Your Present Weight _____ lbs		
Feeling Too Hot	☐	☐	Your Present Height _____		
			Trouble Sleeping	☐	☐

EYES	YES	NO		YES	NO
Vision/Glasses	☐	☐	Excessive Tearing	☐	☐
Double Vision	☐	☐	Glaucoma	☐	☐
Failing Vision	☐	☐	Other _____		
Pain In Eyes	☐	☐	_____		
Seeing "Floaters"	☐	☐	_____		
Inflammation	☐	☐	_____		
Sensitive to Light	☐	☐	_____		
Dry Eyes	☐	☐	_____		

EARS	YES	NO		YES	NO
Earache	☐	☐	Other _____		
Deafness	☐	☐	_____		
Ringing In Ears	☐	☐	_____		
Discharge	☐	☐	_____		

NOSE / MOUTH	YES	NO		YES	NO
Hay Fever	☐	☐	Sores In Nose	☐	☐
Loss of Smell	☐	☐	Sores In Mouth	☐	☐
Frequent Nose Bleeds	☐	☐	Other _____		
Post-nasal Drip	☐	☐	_____		
Sinus Problems	☐	☐	_____		
Runny Nose	☐	☐	_____		
Chronic Nose Obstruction	☐	☐	_____		
Dentures	☐	☐	_____		

NECK	YES	NO		YES	NO
History of Thyroid Problems	☐	☐	Stiffness	☐	☐
Prolonged Hoarseness	☐	☐	Persistent Swelling In Neck	☐	☐
Sore Throat	☐	☐	Other _____		
Pain In Neck	☐	☐	_____		

MUSCULOSKELETAL	YES	NO		YES	NO
Joint Stiffness	☐	☐	Other _____		
Joint Swelling / Warmth	☐	☐	_____		

FOR MD/PROVIDER USE ONLY _____

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REVIEW OF SYSTEMS (CONTINUED)

LUNGS	YES	NO
Short of Breath Lying Down	☐	☐
Short of Breath at Rest	☐	☐
Short of Breath with Walking or Exercise	☐	☐
Chest Pain with Breathing	☐	☐

	YES	NO
Cough	☐	☐
Cough with Blood	☐	☐
Last PPD (TB) Test Date _____		
Other _____		

FOR MD/PROVIDER USE ONLY

☐ In-Patient ☐ Out-Patient

HEART	YES	NO
Chest Pain with Activity	☐	☐
Heart Skips Beats	☐	☐
Heart Beats Too Fast	☐	☐
Ever Had a Heart Attack	☐	☐
Passing Out Spells	☐	☐
High Blood Pressure	☐	☐

	YES	NO
Heart Murmur	☐	☐
Bad Heart Valve	☐	☐
History of Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Other _____		

STOMACH, INTESTINES, LIVER		
Chronic Abdominal Pain	☐	☐
Persistent Nausea	☐	☐
Frequent Vomiting	☐	☐
Heartburn	☐	☐
Difficulty with Swallowing	☐	☐
Loss of Appetite	☐	☐
Indigestion	☐	☐
Vomit Blood	☐	☐
Skin Turns Yellow	☐	☐

	YES	NO
Clay-colored Stools	☐	☐
Changes in Bowel Habits	☐	☐
Chronic Diarrhea	☐	☐
Any Black Tarry Stools	☐	☐
Any Blood from Rectum	☐	☐
Habitual or New Constipation	☐	☐
Hemorrhoids	☐	☐
Rectal Pain	☐	☐
Other _____		

GENITO-URINARY TRACT (WOMEN)		
Pain with Urination	☐	☐
Frequent Bladder Infection	☐	☐
Can't Hold Urine	☐	☐
Can't Empty Bladder	☐	☐
Have to Urinate More Than Two (2) Times at Night	☐	☐
Blood in Urine	☐	☐
Vaginal Discharge	☐	☐
Heavy Menstrual Periods	☐	☐
Premenstrual Tension	☐	☐
Irregular Menstrual Periods	☐	☐
Severe Pain with Menses	☐	☐

	YES	NO
Passed Any Stones	☐	☐
Age When Menstruation Started _____ Years Old		
Length of Average Cycle _____ Days		
Last Menstrual Period _____ Date		
Number of Pregnancies _____		
Number of Births _____		
Number of Miscarriages _____		
Number of Living Children _____		
Ever Have (Sexually Transmitted) Venereal Disease	☐	☐
Other _____		

GENITO-URINARY TRACT (MEN)		
Pain with Urination	☐	☐
Discharge from Penis	☐	☐
Blood in Urine	☐	☐
Have to Urinate More Than Two (2) Times at Night	☐	☐
Hard or Short Stream	☐	☐
Weak Stream	☐	☐

	YES	NO
Stream Starts and Stops	☐	☐
Dribbling Urine	☐	☐
Passed Any Stones	☐	☐
Ever Have (Sexually Transmitted) Venereal Disease	☐	☐
Other _____		

NEUROLOGIC	YES	NO
Dizziness	☐	☐
Stiffness	☐	☐
Trouble Walking	☐	☐
Persistent Swelling in Neck	☐	☐
History of Stroke	☐	☐
Numbness	☐	☐
Frequent Headaches	☐	☐
Migraine Disorders	☐	☐

	YES	NO
Sleep Disorders	☐	☐
Seizures	☐	☐
Loss of Memory	☐	☐
Paralysis / Weakness	☐	☐
Speech Disturbances	☐	☐
Recent Head Trauma	☐	☐
Other _____		

PSYCHIATRIC	YES	NO
History of Depression	☐	☐
History of Anxiety	☐	☐
Anorexia / Bulimia (Eating Disorders)	☐	☐
Nervous Breakdown	☐	☐
Psychotherapy / Counseling	☐	☐

	YES	NO
Any Alcohol Problems	☐	☐
Any Drug Problems	☐	☐
Any Physical, Verbal, or Sexual Abuse	☐	☐
Other _____		

SKIN	YES	NO
Rash	☐	☐
Rash with Sun Exposure	☐	☐
Loss of Hair	☐	☐
Fingers Turn Color in Cold	☐	☐
Skin Dryness	☐	☐

	YES	NO
Itching	☐	☐
Bleeds or Bruises Easily	☐	☐
Concerning Skin Sores/Spots	☐	☐
Psoriasis	☐	☐
Skin Thickening	☐	☐

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MEDICATIONS AND ALLERGIES

Please list all of your **MEDICATION ALLERGIES**:

MEDICATION:	**REACTION**:

☐ In-Patient ☐ Out-Patient

If you need additional space **CHECK HERE** ☐ *and use the back of this page.*

Please list all of your current **PRESCRIPTION MEDICATIONS**: (If you have prepared a prescription medication list already, please bring in your list, and we will complete this section. Also, it will be helpful if you bring with you all of your medications in bottles.)

MEDICATION	**DOSAGE**	**NUMBER OF TIMES/DAY**	**REASON FOR WHICH YOU TAKE THIS**

If you need additional space **CHECK HERE** ☐ *and use the back of this page.*

Please list all of your current **OVER-THE-COUNTER MEDICATIONS, VITAMIN SUPPLEMENTS, FIBER SUPPLEMENTS, SUPPOSITORIES, HERBAL REMEDIES, ETC.**: (If you have prepared a prescription medication list already, please bring in your list, and we will complete this section. Also, it will be helpful if you bring with you all of your medications in bottles.)

MEDICATION	**TIMES/DAY**	**MEDICATION**	**TIMES/DAY**	**MEDICATION**	**TIMES/DAY**

PAST MEDICAL SURGICAL HISTORY

PLEASE LIST ALL OF YOUR OPERATIONS/SURGERIES	DATE	PLEASE LIST ALL OF YOUR DIAGNOSES

PLEASE GIVE DATES AND REASONS FOR ANY HOSPITALIZATION WHICH YOU WERE NOT IN FOR SURGERY

APPROXIMATE DATE/REASON		APPROXIMATE DATE/REASON	

SOCIAL HISTORY

PLEASE LIST THE NAME AND PHONE NUMBER OF AN ***EMERGENCY CONTACT PERSON***? ( )

How many years of school have you completed? _____ Your Current Employment Status

Previous Occupations / Jobs

Have your symptoms caused you to miss or stop work? ☐ Yes ☐ No

Are you currently married? ☐ Yes ☐ No If yes, your spouse's name

Do you live: ☐ Alone ☐ With Spouse Only ☐ With Spouse and Children ☐ Other

Is there anything about your religious or cultural beliefs that could affect your medical care? ☐ Yes ☐ No

If yes, please specify

Do you exercise routinely? ☐ Yes ☐ No If yes, describe your exercise activities, including frequency

Last dental exam date _____ Any Dental Problems? (specify)

Have you used any of the following substances?

SUBSTANCE	CURRENTLY USE?	PREVIOUSLY USE?	TYPE/AMOUNT/FREQUENCY	HOW LONG? (Years)	IF STOPPED, HOW LONG? (Years)
Caffeine: Coffee, Tea, Soda	☐ No ☐ Yes	☐ No ☐ Yes			
Tobacco	☐ No ☐ Yes	☐ No ☐ Yes			
Alcohol	☐ No ☐ Yes	☐ No ☐ Yes			
Recreational/Street Drugs	☐ No ☐ Yes	☐ No ☐ Yes			

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FAMILY HISTORY

FATHER ☐ ALIVE (Age _____) ☐ DECEASED (Age _____) ☐ UNKNOWN

Cause of Death _____

☐ In-Patient ☐ Out-Patient

MOTHER ☐ ALIVE (Age _____) ☐ DECEASED (Age _____) ☐ UNKNOWN

Cause of Death _____

	NUMBER ALIVE	APPROXIMATE AGES	NUMBER DECEASED	APPROXIMATE AGE(S) AT DEATH	CAUSES OF DEATH	
Brothers						☐ UNKNOWN
Sisters						☐ UNKNOWN
Sons						☐ UNKNOWN
Daughters						☐ UNKNOWN

Place a check mark v· in the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Check "NONE" if you are not aware of any relative having the illness/condition. Describe the illness/condition.

If you need additional space **CHECK HERE** ☐ *and use the back of this page.*

ILLNESS / CONDITION	FAMILY MEMBERS: GRANDPARENT	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	DESCRIPTION
Cancer (Describe the type of cancer for each person)								
Heart Disease								
Diabetes								
Stroke / TIA								
High Blood Pressure								
High Cholesterol or Triglyceride								
Liver Disease								
Alcohol or Drug Abuse								
Anxiety, Depression, or Psychiatric Illness								
Tuberculosis (TB)								
Anesthesia Complications								
Genetic Disorder								
Kidney Disease								
Rheumatoid Arthritis / Lupus								
Other Autoimmune Disease (Specify)								
Other (Describe)								

Additional Information about your family that you want us to know _____

ADULT PREVENTIVE CARE MEASURES

Please indicate whether you have had these preventive care measures, performed on a regular basis, as recommended:

TEST / VACCINATION	STARTING AGE	FREQUENCY	YES	NO	DATE OF LAST TEST OR VACCINE
Serum Cholesterol	20	Every 5 Years	☐	☐	
Mammogram (Women Only)	40	Every 1-2 Years	☐	☐	
Pap Smear (Women Only)	18	Every 1-3 Years	☐	☐	
Sigmoidoscopy	50	Every 5 Years	☐	☐	
Colonoscopy	50	Every 10 Years	☐	☐	
Colonoscopy	50	Every 10 Years	☐	☐	
Guiac-based (gFOBT)	50	Every Year	☐	☐	

TEST / VACCINATION	STARTING AGE	FREQUENCY	YES	NO	DATE OF LAST TEST OR VACCINE
Fecal Immunochemical (iFOBT)	50	Every Year	☐	☐	
Vision / Glaucoma	40	Every 2-4 Years	☐	☐	
Tetanus-Diphtheria	18	Every 10 Years	☐	☐	
Pneumovax	65	once, may need repeated	☐	☐	
Influenza Vaccines	65	Every Year	☐	☐	
PSA (Men Only)	50	Every Year **(If Recommended)**	☐	☐	

REVIEWER

PHYSICIAN / CARE PROVIDER