# Genesee Medical Group

7830 Clairemont Mesa Blvd. Suite 100, San Diego, CA 92111

Confidential Medical History: Please answer all questions. If you do not know the answer, or do not understand the questions, please insert a question mark (“?”). Please do not leave questions blank. Thank you.

**PATIENT NAME:**______________________________________________ ________________
LAST FIRST MIDDLE DATE

**CHIEF COMPLAINT:**
List any problems for which you are seeking medical care and the approximate date of onset. If you require additional space, please use a separate piece of paper.

| | Problem | Onset |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4 | | |

**PAST MEDICAL HISTORY:**
Chronographically list any surgical procedures or major illnesses requiring ongoing treatment or hospitalization. If you require additional space, please use a separate piece of paper.

| | Procedure or Illness | Date |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**CURRENT MEDICATIONS:**
Please list ALL medications you are currently taking, including over-the-counter medications taken regularly, natural supplements and hormones. If you require additional space, please use a separate piece of paper for your medication list. For your health and safety, we require updated medication information at EACH visit. List additional medications on back.

| | Medication | Dose | Directions | How long taken? |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

**FAMILY HEALTH:**
Please give the following information about your immediate family.

| Relation | Current Age | Age at Death | State of Health / Cause of Death |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Siblings | | | |
| Grandparents | | | |

Have any immediate relative had any of the following? If so, please indicate who.
Diabetes__________ Cancer____________ Allergies___________ Migraine___________
Tuberculosis________ Blood Disease __________ Abnormal Bleeding or Clotting________

## REVIEW OF SYSTEMS:

Please answer all questions. Do not leave blanks.

| **RESPIRATORY SYSTEM** | **NO** | **YES** | **PHYSICIAN'S COMMENTS** | **DIGESTIVE** (CONTINUED) | **NO** | **YES** |
|---|---|---|---|---|---|---|
| Have you ever had any of the following….. | | | | Have you ever had any of the following….. | | |
| Pneumonia | | | | Liver trouble | | |
| Emphysema | | | | Gallbladder / stones | | |
| Tuberculosis | | | | Colitis / persistent diarrhea | | |
| Tuberculosis skin test | | | | Diverticulitis | | |
| Asthma or wheezing | | | | Bloody stools | | |
| Exposure to dust or fumes | | | | Have you had X-rays? | | |
| Abnormal chest X-ray | | | significant for | Stomach (GI series) | | |
| Do you often cough? | | | ❑ chest pain | Gallbladder | | |
| Have you coughed up blood? | | | ❑ claudication | Bowel (barium enema) | | |
| Do you smoke? | | | ❑ dyspnea | **URINARY** | | |
| Do you get colds often? | | | | Have you had any of the following? | | |
| When was your last chest X-ray?________________ | | | | Kidney disease / nephritis | | |
| **CIRCULATORY** | | | | Protein in the urine | | |
| Have you ever had any of the following….. | | | | Blood / pus in the urine | | |
| Heart murmur | | | | Kidney stones | | |
| Heart attack | | | | Urinary infections | | |
| Angina pectoris | | | | Prostate trouble | | |
| High cholesterol | | | | Syphilis or gonorrhea | | |
| High blood pressure | | | | OB/BYN | | |
| Severe chest pain | | | | Have you ever had breast lumps? | | |
| Heart failure | | | | How many pregnancies have you had?_________ | | |
| Abnormal EKG | | | | Are you taking hormones? | | |
| Normal EKG | | | | Are you taking BCPs? | | |
| Swelling of ankles | | | | Date of last PAP?___________ | | |
| Rheumatic Fever | | | | Are your periods normal? | | |
| **ENDOCRINOLOGY** | | | | **NEUROLOGICAL** | | |
| Have you ever had any of the following….. | | | | Have you ever had any of the following….. | | |
| Thyroid disease | | | | Frequent headaches | | |
| Diabetes | | | | Loss of consciousness | | |
| **DIGESTIVE** | | | | Convulsions / seizures | | |
| Do you regularly have… | | | significant for | Head injury | | |
| Trouble swallowing | | | ❑ abdominal pain | Stroke or paralysis | | |
| Heartburn | | | | Double vision | | |
| Nausea or vomiting | | | Counseling | Depression / hopelessness | | |
| Abdominal pain | | | ❑ Drug Use | Deafness | | |
| Constipation | | | | Visual impairment | | |
| Diarrhea | | | ❑ Smoking | **ALLERGY/IMMUNOLOGY** | | |
| Any change in bowel function? | | | ______ packs/day | Have you ever had any of the following….. | | |
| Have you lost weight? | | | | Hives | | |
| Have you ever had…. | | | ❑ Alcohol | Rash | | |
| Ulcer | | | _______ /day | Hay fever | | |
| Hiatal or esophagus hernia | | | _______/week | Persistent stuffiness | | |
| Vomiting blood | | | | **ORTHOPEDIC** | | |
| Black or tarry stools | | | | Do you suffer from bone or joint pain? | | |