Genesee Medical Group

3880 Murphy Canyon Rd. Suite 120, San Diego, CA 92123

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?		