SUSANNA I. CHOU, M.D., PH.D.
BOARD-CERTIFIED FAMILY PRACTICE

Medical History Form

Patient Name: _____ Date of Birth: _____ Date: _____

Please answer the following questions. If yes, please explain

Description

Y N **General**

- ❑❑ Poor Appetite _____
- ❑❑ Weight loss/gain _____
- ❑❑ Chills/fever _____
- ❑❑ Night Sweats _____
- ❑❑ Skin rashes _____
- ❑❑ Sores/open wounds _____

Y N **Head/Neck**

- ❑❑ Visual problems _____
- ❑❑ Hearing Impaired _____
- ❑❑ Nose bleeds _____
- ❑❑ Sore mouth/throat _____
- ❑❑ Neck swelling _____
- ❑❑ Neck stiffness _____

Y N **Pulmonary**

- ❑❑ Shortness of breath _____
- ❑❑ with exercise _____
- ❑❑ laying down _____
- ❑❑ Chronic cough/bronchitis _____
- ❑❑ Sputum/bloody sputum _____
- ❑❑ Asthma/Wheezing _____
- ❑❑ Pneumonia _____

Y N **Heart**

- ❑❑ Chest Pain _____
- ❑❑ Heart Attack _____
- ❑❑ Irregular heart beats _____
- ❑❑ Rheumatic fever _____

Y N **Gastrointestinal**

- ❑❑ Difficulty Swallowing _____
- ❑❑ Nausea/Vomiting _____
- ❑❑ Ulcers _____
- ❑❑ Diarrhea _____
- ❑❑ Constipation _____
- ❑❑ Hemorrhoids _____
- ❑❑ Black/bloody stools _____
- ❑❑ Abdominal pain _____

Description

Y N **Urinary**

- ❑❑ Bladder infections _____
- ❑❑ Urinating frequently/pain _____
- ❑❑ Difficulty controlling urine _____
- ❑❑ Blood or stones
  Transmitted Disease _____

Y N **Musculoskeletal**

- ❑❑ Muscle/bone/joint disease _____
- ❑❑ Arthritis _____
- ❑❑ Weakness/paralysis _____
- ❑❑ Swelling ankles/feet _____
- ❑❑ Pain when walking _____

Y N **Neurological**

- ❑❑ Headaches _____
- ❑❑ Dizziness/fainting _____
- ❑❑ Tremors/seizures _____
- ❑❑ Numbness/tingling _____
- ❑❑ Stroke _____

Y N **Male**

- ❑❑ Discharge _____
- ❑❑ Sores on penis _____
- ❑❑ Enlarged/painful testicles _____

Y N **Female**

Menstrual: Age menses began_____
Duration_____ Interval_____
Date of last period_____
Pregnancies:
Number_____ Full Term_____
Premature_____ Abortions/Miscarr_____
Now Alive_____

- ❑❑ Pain/abnormal bleeding _____
- ❑❑ Discharge _____
- ❑❑ Breast Lumps _____
- ❑❑ Breast pain/tenderness _____
- ❑❑ Discharge from nipples _____
- ❑❑ Other _____