SENTARA
RMH Medical Center

PATIENT HISTORY/PROBLEM SUMMARY LIST

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Medical Record # **Date:**

Last Name		**First Name**	**Middle Initial**
Date of Birth	**Age**	**Sex:** **Male** **Female**	**Primary Care Physician**

Allergies:
Please list all medication, food, and environmental allergies:
_____
_____

Current Medications:
Please list ALL and how often you take them (e.g. sprays, inhalers, ointments, drops, pills, injections and dosage). Include all herbal, alternative and over-the counter medications. ☐ **Currently not taking any medications**

1.)	8.)
2.)	9.)
3.)	10.)
4.)	11.)
5.)	12.)
6.)	13.)
7.)	14.)

Patient Medical History (Please check if you ever had or now have)

☐ Arthritis	☐ Glaucoma (HEENT)
☐ Asthma	☐ Gout (Musc)
☐ Cancer (Type: _____)	☐ Hay Fever (Immun)
☐ Depression	☐ Heart Trouble (Cardio)
☐ Diabetes	☐ Pneumonia (Pulmonary)
☐ High Blood Pressure (Hypertension)	☐ Pulmonary Tuberculosis (Pulmonary)
☐ Osteoporosis	☐ Serious Infections
☐ Seizure Disorder	☐ Severe Back Pain (Musc)
☐ Thyroid Problems (Disease)	☐ Sexual Disease (Infec)
☐ Mental Illness	☐ Stroke (Neuro)
☐ Anxiety / Depression	☐ Ulcer(s) (GI)
☐ Bleeding Disorder (Hematologic)	☐ Disability (Misc)
☐ Blood Transfusion (Hematologic)	☐ None of these

List surgeries and past hospitalizations you have had:

1.)
2.)
3.)
4.)

FAMILY HISTORY OF:	**YES**	**NO**	(If Yes, please indicate relationship and age disease was diagnosed if known)
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Stroke	☐	☐	_____
Mental Illness	☐	☐	_____
Anxiety/Depression	☐	☐	_____
Other?			_____

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PATIENT HISTORY (continued)

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

Social History: _____

Primary Language: **Ethnic Origin:**

Education: **Advanced Directive:** ☐ Yes ☐ No

Occupation:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Current Use of Tobacco:
☐ Current User of Tobacco Type: _____ Packs/Container per day: _____
Years used: _____ Ever tried to quit? _____

Frequency:
☐ Every day smoker ☐ Unknown frequency ☐ Former Smoker
☐ Some day smoker ☐ Never smoker Quit Date: _____
☐ Unknown if ever smoked

Current Use of Alcohol:
☐ Never ☐ Occasionally ☐ Used to Amount: _____

Have you ever used these drugs? (Confidential) ☐ Yes ☐ No
☐ Marijuana ☐ Cocaine ☐ Heroin ☐ IV Drugs ☐ Other: _____

Do you currently use illegal drugs? (Confidential) ☐ Yes ☐ No

Please place a check in the box if you have had the following in the past

Constitutional
☐ Insomnia

HEENT
☐ Eye Disease or Injury

Respiratory
☐ Has a positive PPD
☐ Had any chest illness w/in past 3 years that has prevented regular activities?

Cardiovascular
☐ Chest pain or angina
☐ Palpitations
☐ Shortness of breath with walking
☐ Fast heartbeat
☐ Slow heartbeat
☐ Slow to heal after cuts

Gastrointestinal
☐ Peptic ulcer
☐ Frequent diarrhea
☐ Blood in stool
☐ Rectal bleeding

Genitourinary
☐ Kidney Stones

Female
☐ Estrogen replacement
☐ Abnormal PAP
☐ Breast lump

Metabolic/Endocrine
☐ Weight Loss
☐ Weight Gain

Neurological/Psychiatric
☐ Frequent or recurring headaches
☐ Tremors
☐ Paralysis
☐ Learning Disability
☐ Anxiety
☐ Depression
☐ Head Injury
☐ Loss of Consciousness
☐ Frequent Falls
☐ Speech or Visual Changes
☐ Memory loss or confusion

Dermatologic
☐ Recurrent Rash
☐ Skin lesion biopsy

Musculoskeletal
☐ Joint stiffness

Hematologic
☐ Anemia
☐ Bleeding or bruising tendency

Immunologic
History of skin or adverse reaction
☐ Penicillin or other antibiotics
☐ Morphine, Demerol
☐ Other narcotics
☐ Novocain
☐ Aspirin
☐ Tetanus antitoxin/other serums
☐ Iodine, merthiolate or antiseptic

When was your last:

PSA (males only)_____
PAP (females only)_____
Mammogram_____
Colonoscopy _____
Bone Density Test_____
Tetanus Vaccine _____
Pneumovax _____

Provider Reviewed: _____ Date: _____

Revised 02/14