

GENERAL MEDICAL INFORMATION SHEET
FMS

Name _____ SS# _____ Date _____
 Birth Date _____ Chief Complaint _____

DRUG ALLERGIES
_____ _____ _____
CURRENT MEDS
_____ _____ _____ _____ _____ _____

<u>FAMILY HISTORY</u>						
	father	mother	father's parents	mother's parents	siblings	children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Number of: Brothers: _____ Sisters: _____						

<u>HOSPITALIZATION OR SURGERY</u>			
Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ___Yes ___No Planning Pregnancy? ___Yes ___No

PAST MEDICAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Headache _____
<input type="checkbox"/> Shortness of Breath _____
<input type="checkbox"/> Heart Palpitations _____
<input type="checkbox"/> Heart Murmur _____
<input type="checkbox"/> Chest Pain _____
<input type="checkbox"/> Dizziness/Fainting _____
<input type="checkbox"/> Peripheral Vascular Disease _____
<input type="checkbox"/> Allergies/Hay Fever _____
<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Bronchitis _____
<input type="checkbox"/> Pneumonia _____
<input type="checkbox"/> Ulcer _____
<input type="checkbox"/> GI Disorder _____ | <input type="checkbox"/> Gall Bladder Disease _____
<input type="checkbox"/> Prostate Disease _____
<input type="checkbox"/> Bowel Irregularity _____
<input type="checkbox"/> Sexual/Menstrual
Dysfunction _____
<input type="checkbox"/> Venereal Disease _____
<input type="checkbox"/> Frequent Infections _____
<input type="checkbox"/> Hepatitis _____
<input type="checkbox"/> Anemia _____
<input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Nervousness _____
<input type="checkbox"/> Depression _____
<input type="checkbox"/> Gout _____ | <input type="checkbox"/> Chronic Rashes _____
<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Mumps _____
<input type="checkbox"/> Measles _____
<input type="checkbox"/> Rubella _____
<input type="checkbox"/> Polio _____
<input type="checkbox"/> Diphtheria _____
<input type="checkbox"/> Tetanus _____
<input type="checkbox"/> Other _____ |
|---|---|--|

HABITS

- | | | |
|--|--|---|
| <input type="checkbox"/> Smoke: Packs daily _____
<input type="checkbox"/> Exercise routine _____
<input type="checkbox"/> Alcohol: Type/Amount _____
<input type="checkbox"/> Diet: Salt intake _____
<input type="checkbox"/> Contact with blood or body fluid at work _____ | How long? _____
Coffee: Cups daily _____
Sleep pattern _____
Fat intake _____ | When stopped? _____
Other caffeine _____ |
|--|--|---|

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