Exhibit A: Medical History Form

History #  
UPIN #  

(Please leave blank)

Name:  
First  M.I.  Last  

Address:  
Street  (Apt #)  

City  State  Zip Code  

Phone number:  
(   )  
Home  
(   )  
Business  

Birth Date:  
/ /  
Day-Month-Year  

Gender:  
M  F  

Marital status:  
(Maiden name  

Ethnic Background:  
☐ Caucasian  ☐ African-American  ☐ Asian  ☐ Hispanic  ☐ Native American  

Occupation:  
Current  Duration  months  years  

Previous  ___  ___  

___  ___  ___  

___  ___  ___  

Hobbies/Leisure activities:  

Toxic exposures with dates:  (insecticides___, solvents___, chemicals___, 

fumes___, asbestos___, irradiation___)  

Family pets:  

Foreign travel:  
☐ Europe  Dates  
☐ Asia  
☐ South America  
☐ Africa  


Tobacco use: Type ____________ Amount ____________ Duration ____________

Alcohol use: Type ____________ Amount ____________ Duration ____________

**Family Medical History:**

Father: □ living; age ____________ □ deceased; age ____________

Illnesses __________________________________________

Mother: □ living; age ____________ □ deceased; age ____________

Illnesses __________________________________________

Siblings: Brothers □ living; ages ____________, □ deceased; ages ____________

Sisters □ living; ages ____________, □ deceased; ages ____________

Illnesses __________________________________________

Children: Male; ages ____________ Female; ages ____________

Illnesses __________________________________________

Diseases that run in the family: (circle all that apply)
Lung Disease    Skin Disease    Stroke    Cancer
Tuberculosis    Arthritis    Blood Clots    Gout
Heart Disease    Diabetes    Anemia    Kidney Stones
Kidney Disease    Hypertension    Leukemia    Birth Defects or
Liver Disease    Bleeding Disorders    Other Blood Disorders    Inherited Disorders

**Personal Medical History:**

**Hospitalizations:**

Dates: ____________, ____________, ____________

Hospital ____________

Reason ____________

**Surgery:**

Dates: ____________, ____________, ____________

Hospital ____________

Type ____________

**Injuries:**

Dates: ____________, ____________, ____________

Type ____________

**Medicine allergies: (Drug and type of reaction)** ____________, ____________

**Pregnancies:**

Full term ______, ________ Miscarriages ______, ________
Personal Medical History (Continued):
Current medications (including vitamins and nonprescription drugs):


Immunizations (with dates):
Tetanus, Pneumovax, Influenza, Hepatitis A, Hepatitis B

Blood donations given, Dates:

Blood transfusions received, Dates:

Blood studies performed: □ Bone marrow aspiration, Dates
□ Bone marrow biopsy, Dates

Symptom Review (Check and complete all that apply)

Constitutional: Have you recently experienced?
□ Fever
□ Night sweats
□ Weight loss, Amount
□ Poor appetite
□ Weight gain, Amount
□ Lack of energy
□ Weakness
□ Difficulty sleeping

Head
□ Headaches; Type Duration Treatment
□ Earache □ Right ear □ Left ear
□ Loss of hearing, □ Right ear □ Left ear
□ Ringing in the ear □ Right ear □ Left ear
□ Dizziness or vertigo
□ Loss of vision, □ Right eye □ Left eye
□ Double vision
□ Spots or flashing lights □ Right eye □ Left eye
□ Nose bleeds
□ Sinusitis
□ Gum bleeding
□ Sore or burning tongue
□ Mouth ulcers or sores

Neck
□ Sore throat
□ Hoarseness
□ History of thyroid disease or goiter, Date, Treatment
□ Heat or □ Cold intolerance, Duration

Chest
□ Pain
□ Sputum production
□ Cough
□ Snoring or sleep apnea
□ Asthma
□ Bloody sputum
□ Shortness of breath: □ At rest □ With exertion □ Lying down
□ Last chest x-ray, Date
□ TB skin test; □ Positive; □ Negative; Dates

Breasts:
□ Pain
□ Lumps, cysts
□ Discharge

Heart:
□ Rheumatic Fever
□ Heart murmur, Duration
□ Hypertension, Duration
□ Irregular heartbeat, Duration
□ History of heart attack, Date
□ Chest pain with exertion, Duration
□ Ankle swelling, Duration
□ Pain in legs when walking, Duration
Abdomen
- □ Inability to eat a full meal
- □ Change in abdominal size
- □ Difficulty swallowing
- □ Heartburn or Acid-indigestion
- □ Peptic ulcer
- □ Food intolerance, type __________
- □ Antacid use
- □ Hiatus hemia
- □ Specific food or ice craving
- □ Abdominal pain
  - Location ______
  - Duration ______
- □ Vomiting
- □ Vomiting blood
- □ Blood in the stool
- □ Black or tarry stools
- □ Change in bowel habits, Duration ______
- □ Constipation
- □ Diarrhea
- □ Laxative use, type __________

Genitourinary Tract
- □ Pain with urination
- □ Bleeding
- □ Urinary urgency
- □ Increased frequency
- □ Kidney stones
- □ Kidney infection, Dates ______
- □ Bladder infection, Dates ______
- □ Change in urine color
- □ Getting up at night to urinate
- □ Bleeding between menstrual periods
- □ Excessive menstrual bleeding
- □ Vaginal infection
- □ Vaginal discharge

Bones and Joints
- □ Joint pain
- □ Joint swelling
- □ Joint stiffness
- □ Numbness or tingling (pins and needles in hands or feet)
- □ Gout
- □ Pain in the arms, legs, hands or feet
- □ Burning pains in the hands or feet

Muscles
- □ Muscle pain
- □ Muscle stiffness
- □ Muscle cramps

Nervous System
- □ Fainting episodes
- □ Seizures
- □ Stroke
- □ Temporary loss of vision
- □ Memory loss
- □ Difficulty sleeping
- □ Depression

Blood:
- □ Anemia, Dates: ______, _______. Treatment _______. Result _______.
- □ Abnormal blood counts, Type __________, Dates: __________.
- □ Bleeding, Dates ______. Treatment __________
- □ Phlebitis or blood clots; Site ______. Dates _________, __________
- □ Swollen lymph nodes, location __________

Skin:
- □ Rash
- □ Itching after a shower, bath or exercise
- □ Hair loss
- □ Hair gain
- □ Excema
- □ Psoriasis
- □ Change in skin color
- □ Change in skin texture
Present Illness:

Provide a description of your illness with dates of onset of symptoms, tests performed and treatments given. Please also indicate your concerns. Use additional paper as needed.