Rocky Top Medical Center

DATABASE TOOL

Medical and Personal History

Patient Name: _____ Date: _____

DOB: _____ Sex: M / F Time: _____

Chart #: _____

For what reason are you here today? _____

_____

_____

Please check conditions which you have had

GENERAL
- ☐ Serious Infections (e.g. pneumonia):_____
- ☐ Diabetes Mellitus
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer (where?):_____

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT
- ☐ Glaucoma
- ☐ Allergies "hay fever"
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lungs
- ☐ Sleep Apnea

MUSCULOSKELETAL/ EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (Herniated disc)
- ☐ Back Pain (Herniated disc)

LYMPHATIC / HEMATOLOGIC
- ☐ Thyroid Goiter
- ☐ Over Active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusions
- ☐ Anemia

GI / GU
- ☐ Stomach Ulcers
- ☐ Ulcerative Collitis
- ☐ Crohns Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones

- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sex Transmitted Infection

SKIN / BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC / PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

Doctor's Notes: _____

_____

_____

Please indicate any surgeries you have had and the year you had them.

Year		Year		Year		Year	
___	Angioplasty	___	Trauma Related Surgery	___	Stomach Surgery	___	Tubal Ligation
___	Carotid Artery Surgery	___	Back or Neck Surgery	___	Inguinal Hernia	___	C-Section
___	Other Vascular Surgery	___	Hip Surgery	___	Colonoscopy	___	Hysterectomy
___	Coronary Bypass Surgery	___	Knee Surgery	___	Gallbladder	___	Ovary Removed
___	Chest/Lung Surgery	___	Carpal Tunnel Surgery	___	Appendectomy	___	Breast Surgery
___	Tonsillectomy	___	Sinus Surgery	___	Prostate Surgery	___	Thyroid Surgery
___	Neurosurgery	___	Ear Surgery	___	Bladder Surgery	other	_____

Doctor's Notes: _____

_____

_____

Please indicate when you last had any of the following preventative tests or services

Year:		Year		Year		Year	
___	Cardiac Angiogra	___	Flu Vaccine	___	Prostate Cancer Blood Test	___	Pap Smeer
___	Stress Test	___	Pneumonia Vaccine	___	Rectal Exam	___	Date of Last Physical Exam
___	Echocardiogram	___	Tetanus Vaccine	___	Colon Cancer Stool Test	___	HbgIAC
___	Chest X-ray	___	Hepatitis Vaccine	___	Flexible Sigmoidoscopy	___	Eye Exam
___	EKG	___	Bone Density Test	___	Mammogram/Breast Exam	___	Glucose Tolerance Test

Doctor's Notes: _____

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