Wayne M. Duran, MD
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Phone: 253-288-8882
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FD:_____
MA:_____
DR:_____

Medical History Form

_____ _____
(Last, First) (DOB)

Please complete **all** pages. We understand you may have filled this form out on your last visit, however for **each** visit we are required to update your information. Your answers on this form will help our staff understand your medical concerns and conditions better and faster. **Thank you!**

HISTORY OF PRESENT ILLNESS Please address every question.

CHIEF COMPLAINT	What is the reason for your visit?	
LOCATION	Where do your symptoms exist?	
CONTEXT	What were you doing when this problem occurred?	
QUALITY	Describe how your problem feels.	
TIMING	Do your symptoms change based on time of day?	
SEVERITY	How serious is what you're experiencing on a 10 point scale?	
DURATION	How long have these symptoms been present?	
MODIFYING FACTORS	What improves OR worsens your symptoms?	
ASSOCIATED SIGNS AND SYMPTOMS	Are there any other symptoms that you think are related to your chief complaint?	

REVIEW OF SYSTEMS Please check any **current or PAST** problems you may have on the list below/

Constitutional
___Fever/ Chills, sweats
___Unexplained weight loss/gain
___Fatigue/ weakness
___ Excessive thirst or urination.
Eyes
___Change in vision
Ears/nose/throat/mouth
___Difficult hearing/ringing in ears
___Problems with teeth/ gums
___Hay fever/ allergies
Cardiovascular
___Chest pain/ discomfort
___ Leg pain with exercise
___ Palpitations

Chest (breast)
___ Breast lump/ discharge
Respiratory
___Cough/wheeze
___Difficulty breathing
Gastrointestinal
___ Abdominal pain
___Blood in bowel movement
___Nausea/ vomiting/diarrhea
Genitourinary
___ Night time urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems
Musculo-skeletal
___ Muscle-joint pain

Skin
___Rash or mole change
Neurological
___ Headaches
___ Dizziness/ light-headedness
___ Numbness
___Memory loss
___Loss of coordination
Psychiatric
___Anxiety/ stress
___Problems with sleep
___Depression
Blood/Lymphatic
___Unexplained Lumps
___Easy Bruising/bleeding

Other _____

OVER→

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SOCIAL HISTORY

EMOTIONS

1. In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually care about or enjoyed? □ **YES** □ **NO**
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
   □ **YES** □ **NO**
3. Have you felt depressed or sad much of the time in the past year? □ **YES** □ **NO**

SOCIOECONOMICS

1. **Occupation** _____
2. **Education completed**
   □ Grade School
   □ High School
   □ College
   □ Graduate School
   Total years of Education _____
3. **Marital Status**
   □ Single
   □ Married
   □ Separated
   □ Divorced
   □ Widowed
   □ Cohabitating
   □ Engaged
   □ Other _____
   Spouse's Name _____
   Number of Children_____
   *Who Lives at home with you?*_____
   _____

SEXUALITY

7. **Sexual Activity**
   Are you sexually active?
   □ Yes □ No □ Not Currently
   Current Sexual partner(s) is/are
   □ Male □ Female
8. **Contraception and Protection**
   a. *Birth Control Method*_____
   □ **None needed**
   b. If sexually Active, do you practice safe sex?
   □ **YES** □ **NO**
   c. Have you ever had any sexually transmitted diseases? (STD)
   □ **YES** □ **NO**
9. If yes, please include:
   _____

EXERCISE

1. *Do you exercise regularly?* □ YES □ NO

SAFETY

1. Do you use seatbelts consistently?
   □ **YES** □ **NO**
2. Do you use a bike helmet regularly
   □ **YES** □ **NO**
3. Is violence at home a concern for you?
   □ **YES** □ **NO**
4. Do you feel safe in your current relationship?
   □ **YES** □ **NO**
5. Do you have a gun in your home?
   □ **YES** □ **NO**
6. Other concerns? _____

SUBSTANCES

1. **Tobacco Use**
   Do you smoke cigarettes?
   □ Never
   □ Former- Quit Date:_____
   □ Current- Pack/Day:_____ Years:_____
   Do you use other Tobacco Products?
   □ Pipe
   □Cigar
   □Snuff
   □chew
   Are you interested in quitting?
   □Yes □ No
2. **Alcohol Use**
   Do you drink alcohol?
   □ No
   □ Yes- Drinks/Week:_____
3. **Drug Use**
   Do you use recreational drugs? □ YES □ NO
   Have you ever used needles? □ YES □ NO

PHARMACY:

_____
(name) (city)

ATTACHMENTS:

Please review the attached chart summary for accuracy and complete the following three tasks

1. Review current list of problems.
2. Review current list of medications.
3. Note any changes.

Thank you for your patience and cooperation!