# CYNTHIA T MCCALEB, M.D.

## PAST HISTORY FORM

**NAME: ________________________________________ DATE: _________________**

**PAST MEDICAL HISTORY**

**CHILDHOOD:**

Birth: Normal_____ Abnormal_____

| Illnesses: | NO | Yes |
|---|---|---|
| Mumps | ______ | _____ |
| Measles | ______ | _____ |
| German Measles | ______ | _____ |
| Chickenpox | ______ | _____ |
| Whooping Cough | ______ | _____ |
| Pneumonia | ______ | _____ |
| Rheumatic Fever | ______ | _____ |
| Asthma | ______ | _____ |
| Operations | __________________ | |
| Other | __________________ | |

| Immunizations: | No | Yes |
|---|---|---|
| Polio | _____ | _____ |
| German Measles/ Rubella | _____ | _____ |
| Mumps | _____ | _____ |
| Measles | _____ | _____ |
| HPV | _____ | _____ |
| Shingles | _____ | _____ |
| Chickenpox | _____ | _____ |
| Pneumovax | _____ | _____ |
| TD (tetanus) | _____ | _____ |
| Date Last Tetanus | _________________ | |
| TdaP | _____ | _____ |

**Allergies:**

Medications _________________________

____________________________________

Foods

____________________________________

Other

____________________________________

**ADULTHOOD:**

**Serious Illnesses**

| What: | Date | Physician |
|---|---|---|
| ___________________ | ________ | _________ |
| ___________________ | ________ | _________ |
| ___________________ | ________ | _________ |

**Chronic Illnesses**

| What: | Date | Physician |
|---|---|---|
| ___________________ | _________ | _________ |
| ___________________ | _________ | _________ |
| ___________________ | _________ | _________ |

**Injuries**

___________________ _________ _________

___________________ _________ _________

**Operations**

___________________ ________ ________

___________________ ________ ________

**Other Hospitalizations**

___________________ _________ _______

___________________ _________ _______

**Medications:**

Prescription:

| Name: | Dose: | How Often/When |
|---|---|---|
| ____________________________________ | ___________________ | ___________________ |
| ____________________________________ | ___________________ | ___________________ |

**Continued**

**NAME** ________________________________ **DATE**______________________

**Medications:**
Prescription:

| Name: | Dose | How Often/When |
|---|---|---|
| | | |
| | | |
| | | |

Over the counter drugs:

| | | |
|---|---|---|
| | | |
| | | |
| | | |

Vitamins/Supplements/Herbs

| | | |
|---|---|---|
| | | |
| | | |
| | | |

| **Family History:** | Alive | Dead | Age | Medical Problems |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sister | | | | |
| | | | | |
| Brother | | | | |
| Brother | | | | |
| Spouse | | | | |
| Children | | | | |
| | | | | |

Continued

**Name**____________________________________**Date**____________________

**Social History:**
Occupation:__________________________________________________________

Recreation/Hobby_____________________________________________________

Diet: Average Day

Breakfast __________________________________________________________

Lunch __________________________________________________________

Dinner __________________________________________________________

Snacks __________________________________________________________

Tobacco: Smoke Now_______ In past______ No_______ How long________ Packs per day _______
Other tobacco use: ______________________________________

Alcohol: 2 oz drink or equivalent: _________# a week ________# a day

Caffeine (servings per day): Coffee___________, Tea___________, Cola___________

Any other drugs? _______________________________________________________

Do you see any eye doctor? ____________ How Often? _______________________________

Do you see a dentist? _________________ How Often? _______________________________

Do you wear seat belts? ________________ Do you wear a helmet? _______________________

Are there guns in your home? __________ Are they secured? ____________________________

Exercise: What kind? ________________ How many hours per week? ____________________

Has any blood relatives, including grandparents, aunts, uncles had:

| | NO | Yes | Who |
|---|---|---|---|
| Cardiac arrhythmia | _____ | _____ | ______________________________ |
| High Blood Pressure | _____ | _____ | ______________________________ |
| Heart Attack | _____ | _____ | ______________________________ |
| Other heart disease | _____ | _____ | ______________________________ |
| Stroke | _____ | _____ | ______________________________ |
| Diabetes | _____ | _____ | ______________________________ |
| Thyroid problems | _____ | _____ | ______________________________ |
| Asthma | _____ | _____ | ______________________________ |
| COPD | _____ | _____ | ______________________________ |
| Cancer | _____ | _____ | ______________________________ |
| (What kind?) | _______________________________________________ | | |
| Gallbladder problems | _____ | _____ | ______________________________ |

Continued

**Name___________________________________ Date__________________________**

Has any blood relatives, including grandparents, aunts, uncles had:

| | NO | Yes | Who |
|---|---|---|---|
| Liver disease | ____ | ____ | ________________________________ |
| Crohn's disease | ____ | ____ | ________________________________ |
| Ulcerative colitis | ____ | ____ | ________________________________ |
| Blood problems | ____ | ____ | ________________________________ |
| Skin problems | ____ | ____ | ________________________________ |
| Arthritis | ____ | ____ | ________________________________ |
| Inflammatory arthritis | ____ | ____ | ________________________________ |
| Auto immune disease | ____ | ____ | ________________________________ |
| Parkinson's disease | ____ | ____ | ________________________________ |
| Alzheimer's disease | ____ | ____ | ________________________________ |
| ADHD/Learning disabilities | ____ | ____ | ________________________________ |
| Colon polyps | ____ | ____ | ________________________________ |
| Psychiatric problems | ____ | ____ | ________________________________ |
| Alcoholism/Drug problems | ____ | ____ | ________________________________ |
| Sudden unexplained death | ____ | ____ | ________________________________ |
| Other | ____ | ____ | ________________________________ |

## For Women Only

Date last period: ___________________________ Age first period ___________________________

Cycle (day 1 of period to day 1 of next)_____________days

Problems with period ______________________________

Birth control method if used: Now______________________ Previous____________________________

Problems with birth control method_________________________________________________________

Obstetrics history:

List all pregnancies and outcome by date:

___________________________________________ ____________________________________

___________________________________________ ____________________________________

Date of last pap smear_________________________ Are you sexually active_________________

Have you ever had:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| | | Vaginitis | | | Polycystic ovarian syndrome |
| | | Genital Herpes | | | Fibroids |
| | | Abnormal pap smear | | | Pelvic infections |
| | | Colposcopy/cervical biopsy | | | Rape or threat of rape |
| | | Endometriosis | | | Pain with intercourse |
| | | Tumor or cyst | | | Menopause/menopausal symptoms |
| | | Any other problems | | | |

## For Men Only

Have you ever had:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| | | Sores on penis | | | Penile discharge |
| | | Problems with erections | | | Blood in ejaculate |
| | | Prostate Problems | | | Any sexually transmitted diseases |
| | | Painful sex or ejaculation | | | Are you sexually active |
| | | Tenderness or lumps in testicles | | | Do you examine your testicles Regularly |

## CYNTHIA T MCCALEB, MD

**NAME**________________________________________**DATE**______________________

**REASON FOR VISIT**__________________________________________________________

______________________________________________________________________________

| YES | NO | |
|---|---|---|
| ____ | ____ | Tired |
| ____ | ____ | Recent weight gain or loss |
| ____ | ____ | Fever or chills |
| ____ | ____ | Night sweats |
| ____ | ____ | Excessive sweating |
| ____ | ____ | Hot flashes |
| ____ | ____ | Lumps or swollen glands |
| ____ | ____ | Intolerance to heat & cold |
| ____ | ____ | Excessive thirst |
| ____ | ____ | Increase/decrease body hair |
| ____ | ____ | Thyroid problems |
| ____ | ____ | Diabetes |
| ____ | ____ | Elevated blood glucose |
| ____ | ____ | Eye pain |
| ____ | ____ | Dry eyes |
| ____ | ____ | Glaucoma |
| ____ | ____ | Cataracts |
| ____ | ____ | Other eye problems |
| ____ | ____ | Hearing loss |
| ____ | ____ | Earache |
| ____ | ____ | Ringing in ears |
| ____ | ____ | Dizziness (vertigo) |
| ____ | ____ | Frequent colds |
| ____ | ____ | Stuffy nose or postnasal drip |
| ____ | ____ | Nose bleeds |
| ____ | ____ | Loss of smell |
| ____ | ____ | Frequent sinus infections |
| ____ | ____ | Hay fever/seasonal allergies |
| ____ | ____ | Hoarseness |
| ____ | ____ | Fever blisters |
| ____ | ____ | Gum disease |
| ____ | ____ | Toothache |
| ____ | ____ | Coughing |
| ____ | ____ | Coughing up blood |
| ____ | ____ | Shortness of breath with mild exer |
| ____ | ____ | Awakening at night short of breath |
| ____ | ____ | Wheezing or asthma |
| ____ | ____ | History of pneumonia |
| ____ | ____ | Frequent bronchitis |
| ____ | ____ | TB or positive TB skin test |
| ____ | ____ | History of heart murmur /click |
| ____ | ____ | Palpitations, irregular heart beat |
| ____ | ____ | Chest discomfort or pain |
| ____ | ____ | Swelling of feet or legs |

| YES | NO | |
|---|---|---|
| ____ | ____ | Fainting, lightheadedness |
| ____ | ____ | High cholesterol |
| ____ | ____ | Breast lump |
| ____ | ____ | Fibrocystic breast |
| ____ | ____ | Nipple discharge |
| ____ | ____ | Hx of breast biopsy |
| ____ | ____ | Most recent mammogram |
| ____ | ____ | Do you self examine? |
| ____ | ____ | Increase/decrease in appetite |
| ____ | ____ | Food intolerance |
| ____ | ____ | Trouble swallowing |
| ____ | ____ | Nausea and/or vomiting |
| ____ | ____ | Indigestion |
| ____ | ____ | Change in bowel habits |
| ____ | ____ | Painful bowel movements |
| ____ | ____ | Constipation |
| ____ | ____ | Diarrhea |
| ____ | ____ | Change in stool size |
| ____ | ____ | Bright blood in stools |
| ____ | ____ | Black stools |
| ____ | ____ | Abdominal pain |
| ____ | ____ | Jaundice or hepatitis |
| ____ | ____ | Hemorrhoids |
| ____ | ____ | Rectal itching |
| ____ | ____ | Ulcers |
| ____ | ____ | High alcohol intake |
| ____ | ____ | Pancreatitis |
| ____ | ____ | Pain with urination |
| ____ | ____ | Frequent urination |
| ____ | ____ | Difficulty holding urine |
| ____ | ____ | Difficulty starting urine |
| ____ | ____ | Frequent night urination |
| ____ | ____ | Unusual color of urine |
| ____ | ____ | Blood or pus in urine |
| ____ | ____ | Wetting the bed |
| ____ | ____ | Kidney stones |
| ____ | ____ | Kidney or bladder infection |
| ____ | ____ | Varicose veins |
| ____ | ____ | Pain in legs with walking |
| ____ | ____ | Blood clots in leg veins |
| ____ | ____ | Painful fingers in cold weather |
| ____ | ____ | Painful, swollen or aching joint |
| ____ | ____ | High blood pressure |

Continued

**Name____________________________________Date_________________________**

| Yes | NO | |
|---|---|---|
| ____ | ____ | History of injury to joint |
| ____ | ____ | History of fracture |
| ____ | ____ | Back pain |
| ____ | ____ | Skin rashes |
| ____ | ____ | Hives |
| ____ | ____ | Acne |
| ____ | ____ | Itching |
| ____ | ____ | Skin ulcers |
| ____ | ____ | Lump under skin |
| ____ | ____ | New or changing moles |
| ____ | ____ | Increased/decreased skin pigmentation |
| ____ | ____ | Headaches |
| ____ | ____ | Face pain |
| ____ | ____ | Trouble with balance |
| ____ | ____ | Shaking/Tremors |
| ____ | ____ | Convulsions/seizures |
| ____ | ____ | Problems with concentration/memory |
| ____ | ____ | Numbness |
| ____ | ____ | Weakness |
| ____ | ____ | Problems sleeping |
| ____ | ____ | early awakening |
| ____ | ____ | trouble getting to sleep |
| ____ | ____ | Crying spells |
| ____ | ____ | Poor appetite |
| ____ | ____ | Compulsive eating |
| ____ | ____ | Past suicide attempt or thoughts of suicide |
| ____ | ____ | History of physical, sexual or emotional abuse |
| ____ | ____ | Medicine for nerves or sleep (now or ever) |
| ____ | ____ | Past or present therapy or counseling |
| ____ | ____ | Feel anxious |
| ____ | ____ | Feel depressed |
| ____ | ____ | Recent stresses |
| ____ | ____ | History of anemia |
| ____ | ____ | Prolong bleeding with injury or surgery |
| ____ | ____ | Easy bruising |
| ____ | ____ | Blood transfusion If so, what year __________ |

Anything else your doctor should know? ________________________________________________

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Any problems?

________________________________________________________________________

Any questions?