FMA Patient History Update

PLEASE PRINT

FAMILY MEDICINE ASSOCIATES OF MIDLAND

Patient Name _____ **Date** _____ **MR Number (For Office Use)** _____

This form will give us a better understanding of your health since your last visit. Some questions may not fit your circumstances. It is primarily for patients who have – diabetes, high blood pressure and/or some type of heart disease.

Please circle your responses.

General

Appetite.		Good Poor
Weight Loss.		Yes No
More tired than usual.		Yes No
Weight Gain.		Yes No
Coffee – Cups per day.	0 1 2 3 4 5 More	Caffeine Decaf
Tea – Cups per day.	0 1 2 3 4 5 More	Caffeine Decaf
Alcohol – Drinks per week.	0 1 2 3 4 5 More	
	Wine Beer Other	

Head, Eyes, Ears, Nose, Throat

Double vision.		Yes No
Loss of vision.		Yes No
Last eye doctor appointment.	Date_____	
Nose bleeds.		Yes No

Breathing:

Coughing.		Yes No
If yes, to coughing.		Less More
Coughing with mucous.		Yes No
Color of mucous.	_____	
More short of breath than usual.		Yes No
Wheezing.		Yes No
Waking at night short of breath.		Yes No

If you have been short of breath, circle activities that cause this.

Short walks	Laundry	Vacuuming	Walking up one flight of stairs
Shoveling snow	Mowing	Dishes	Making the bed
Shopping	Yard Work	Ironing	Carrying groceries

Other_____

Patient Signature (parent/guardian if minor) _____ **Date** _____

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Heart

Heart palpitations, racing or flutter feeling.	Yes	No
Leg cramps in your calf or thigh when walking.	Yes	No
Leg cramps at night.	Yes	No
Chest pain or pressure, chest tightness, jaw or left shoulder pain.	Yes	No
Swelling in the ankle area from extra fluid.	Yes	No
Number of pillows used for sleeping.	#_____	
Sleep in a chair at night.	Yes	No
Light-headed or dizzy when getting up out of bed or chair.	Yes	No

Gastrointestinal

Heartburn medicine more than once a week	Yes	No
Diarrhea.	Yes	No
Constipation.	Yes	No
Blood on toilet tissue when wiping.	Yes	No
Black stools or blood in or on your stools.	Yes	No
Bloating or belly pain.	Yes	No

Genitourinary

Waking during night to urinate. (Number of times)	#_____	
Blood in your urine.	Yes	No
Leaking urine.	Yes	No
Increased difficulty emptying bladder – straining more.	Yes	No
Urinating a lot more often.	Yes	No

Neurologic

Fainting spells and/or almost fainting spells.	Yes	No
Concerned about mini-strokes.	Yes	No
Problems with dizziness or change in balance.	Yes	No
Weakness or numbness of one side of body.	Yes	No

Skin

Abnormal color to moles.	Yes	No
Skin spots you want examined.	Yes	No
Often have bruises that are bigger than a dime.	Yes	No
Skin heals well if there have been simple cuts or scrapes.	Yes	No