CAEDEL MEDICAL GROUP, PC

PATIENT NAME: _____ **DOB:** _____

Patient Medical History Form

CHECK ANY OF THE FOLLLOWING SYMPTOMS THAT YOU HAVE HAD RECENTLY

☐	Fever / Chills	☐	Weight Loss	☐	Very Tired	☐	Weakness
☐	Eye Pain	☐	Vision Changes	☐	Drainage from eyes	☐	Ear Pain
☐	Cough	☐	Wheezes	☐	Phlegm	☐	Difficulty Breathing
☐	Nasal Congestion	☐	Sore Throat	☐	Shortness of Breathe	☐	Hearth Palpitations
☐	Chest Pain	☐	Ankle Swelling	☐	Abdominal Pain	☐	Nausea
☐	Vomiting	☐	Constipation	☐	Blood in Stool	☐	Diarrhea
☐	Painful Urination	☐	Blood in Urine	☐	Flank Pain	☐	Bruise easily
☐	Excessive Urination	☐	Execssive Thirst	☐	Headaches	☐	Dizziness
☐	Numbness	☐	Seizures	☐	Passing out	☐	Depression
☐	Anxiety	☐	Hallucination	☐	Suicidal Thoughts	☐	Heat intolerance
☐	Cold Intolerance	☐	Excessive Bleeding	☐	Swollen Glands	☐	Joint Pain
☐	Joint Swelling	☐	Neck Pain	☐	Back Pain	☐	Arm Pain
☐	Leg pain	☐	Rash	☐	Itching	☐	Change in skin

FEMALE

☐	Vaginal Discharge	☐	Vaginal Discharge	☐	Vaginal Discharge	☐	Vaginal Discharge

Last Menstrual Period _____

# of Pregnancies _____ # of Childbirths _____

MALE

☐	Testicle Pain	☐	Discharge from penis

SURGERIES

☐	Appendix	☐	Hernia	☐	Uterus	☐	Tonsils
☐	Tubes Tied	☐	Gallbladder	☐	Heart	☐	

Please List any other surgeries	**Year**

MEDICAL HISTORY

☐	Diabetes	☐	Hypertension	☐	Arthritis	☐	Heart Disease
☐	Stroke	☐	AIDS	☐	Asthma	☐	Cancer

Please list any others not listed above

_____ _____

_____ _____