Recording Patient Medical History

Purpose of Recording a Patient’s Medical History

Completing a patient’s medical health history is extremely important in the treatment of the patient. The following are some of the benefits of recording a patient’s medical history.

- Assists the physician in keeping the patient healthy
- Allows for quicker diagnosis and treatment and a higher degree of success
- Provides the physician with information that assists in narrowing the diseases and treatments that will be successful for the patient

Besides completing the medical history, a medical assistant must also ensure that the patient completes all the nonmedical information forms, such as demographic data, financial information, HIPAA form, and release of medical information form.

Components of a Complete Medical History

A patient’s medical history includes some key pieces of information. They include the following.

- **Chief complaint**—This includes the reason for the patient’s visit in his or her own words.
- **History of present illness**—This includes the length of time that the patient been experiencing the complaint, description of the complaint, and any known injuries.
- **Medical history**—This includes the patient’s medical history, diagnosis, surgeries, medications, and allergies.
- **Family history**—This includes any family history of illnesses of parents, grandparents, and siblings.
- **Social history**—This includes the patient’s alcohol consumption, smoking, exercise, and stress levels.

- **Review of systems**—This step is when the physician completes examining the patient from head to toe.

**Can you recall the last time you visited the doctor’s office? What information did the medical assistant collect from you?**
Example of a Medical History Form

The following is a sample patient medical history form. It includes spaces to record all components of the medical history.

Personal Medical History

Name: ____________________________________
Birthdate:__________________________________
Physician:__________________________________
Telephone numbers:_________________________________________________________________
Dentist:_________________________________________________________________________
Eye doctor:________________________________________________________________________
Other:____________________________________________________________________________
_______________________________________________________________________________
Your current medical condition:
_______________________________________________________________________________
_______________________________________________________________________________
List prescription and non-prescription medications you are taking:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
Drug sensitivity and allergies (describe):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
Name of health insurance carrier:_________________
Group no.:________________________________

Have you ever been told you had one of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung disorder</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Heart trouble</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Nervous disorder</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
Disease or disorder of the digestive tract  yes  no
Any form of cancer  yes  no
Disease of the kidney  yes  no
Diabetes  yes  no
Arthritis  yes  no
Hepatitis  yes  no
Malaria  yes  no
Disease or disorder of the blood? ________________________________
Any physical defect or deformity? ________________________________
Any vision or hearing disorders? ________________________________
Any life-threatening conditions? ________________________________
Any contagious disorders? ________________________________

Do you smoke?_________ Quit?_________ Illegal drugs?________________________

Do you drink?_________ How much?________________________

Personal Medical History
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Have you been treated by a physician or been disabled or hospitalized during the last year?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you had or been advised to have a surgical operation within the last five years?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Date of last physical: ________________________________________________

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Date of last tetanus shot:
______________________________________________________________________

Family history — list important medical problems of your immediate family:
Mother:__________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Father:__________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Brother(s):________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Sister(s):________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Grandmother(s):__________________________________________________________
________________________________________________________________________
________________________________________________________________________

Grandfather(s):____________________________________________________________
________________________________________________________________________
________________________________________________________________________

Any other special medical information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Can you identify the various components of a patient’s medical history in the sample form?