Comprehensive Health Clinic

Medical History Report - Generated on April 19, 2025

Patient Information

Name	John Doe
DOB	01/15/1975
Gender	Male
MRN	MRN12345678
Contact	(555) 123-4567
Email	john.doe@email.com

Chief Complaint

Persistent cough for 2 weeks with mild fever.

History of Present Illness

Patient reports developing a dry cough approximately 2 weeks ago, which has since become productive with clear sputum. Low-grade fever (99.5°F-100.2°F) intermittently present. No chest pain or shortness of breath. Patient has been taking over-the-counter cough suppressants with minimal relief.

Past Medical History

- Hypertension (diagnosed 2015)
- Type 2 Diabetes (diagnosed 2018)
- Appendectomy (2010)

Medications

- Lisinopril 10mg daily

- Metformin 500mg twice daily
- Aspirin 81mg daily
- Multivitamin once daily

Allergies

- Penicillin (hives)
- Sulfa drugs (rash)

Family Medical History

Father: Hypertension, died at 72 from stroke. Mother: Type 2 diabetes, alive at 68. Brother: Asthma.

Social History

Married with 2 children. Works as an accountant. Former smoker (quit 5 years ago, 10 pack-year history). Social alcohol use (2-3 drinks per week). Exercises 2-3 times weekly.

Immunization History

- Influenza vaccine (10/2024)
- Tdap (2020)
- Pneumococcal vaccine (2022)
- COVID-19 vaccine series completed (2021) with booster (2024)

Review of Systems

General: Reports fatigue but no weight loss or night sweats. Respiratory: Cough, no shortness of breath or chest pain. Cardiovascular: No palpitations or edema. Gastrointestinal: No nausea, vomiting, or changes in bowel habits. Neurological: No headaches or dizziness. Musculoskeletal: No joint pain or swelling.