**- MEDICAL CHART SAMPLE USING CONTENT CONTROLS AND CUSTOM XML -**

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| SSN | 36456 | | | | | | | PATIENT ID | | [ID #] |  | | |
| NAME | [Enter Name] | | | | | | | DATE OF BIRTH | | [Enter Date] |
| ADDRESS | [Enter Address] | | | | | | | MARITAL STATUS | | [Select Status] |
| OCCUPATION | [Enter Occupation] | | | | | | | PHONE (H) | | [Home Phone] |
| EMPLOYER | [Enter Employer] | | | | | | | (O) | | [Office Phone] |
|  |  | | | | | | | INSURANCE | | [Insurance] |
| **FAMILY HISTORY** | | | *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE* | | | | | | | | | | |
| 1 EPILEPSY | | 6 THYROID | | | | 11 OSTEOPOROSIS | 16 ALCOHOLISM | | | | | **HISTORY**   |  |  | | --- | --- | | **ITEM** | **RELATION** | | num | relation | | num | relation | | |
| 2 MIGRAINE | | 7 HAYFEVER | | | | 12 ARTHRITIS | 17 CANCER | | | | |
| 3 MENTAL ILL | | 8 ASTHMA | | | | 13 HEART DISEASE | 18 Click here to enter text. | | | | |
| 4 GLAUCOMA | | 9 ANEMIA | | | | 14 STROKE | 19 Click here to enter text. | | | | |
| 5 DIABETES | | 10 BLEEDS EASILY | | | | 15 HYPERTENSION | 20 Click here to enter text. | | | | |
| **HOSPITAL ADMISSIONS**  ***Not to include pregnancies*** | | | | |  |  | | --- | --- | | **YEAR** | **ILLNESS OR OPERATION** | | Click here to enter a date. | Click here to enter text. | | Click here to enter a date. | Click here to enter text. | | | | | | | | | | |
| **MEDICATIONS** | | | | | **ALLERGIES** | | | | **VACCINE** | | | | **TEST / EXAM** |
| |  | | --- | | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | | | | | | |  | | --- | | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | | | | | |  |  | | --- | --- | | TETANUS | Click here to enter a date. | | FLU | Click here to enter a date. | | PNEUMONIA | Click here to enter a date. | | HEPATITIS | Click here to enter a date. | | TUBERCULOSIS | Click here to enter a date. | | | | | |  |  | | --- | --- | | STOOL | Click here to enter a date. | | CHOLEST | Click here to enter a date. | | EYE | Click here to enter a date. | |  |  | |

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| **MEDICAL HISTORY** | | | *MARK (C) FOR CURRENT PROBLEMS. CHECK ☑ AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES* | | | | | | | |
| MAIN PROBLEMS | | | 1) Click here to enter text. | | 2) Click here to enter text. | | | 3) Click here to enter text. | | |
| **Item** | | **Age** | | **Item** | | **Age** | **Item** | **Age** | **Item** | **age** |
| ☐ Decreased Hearing | |  | | ☐ Loss of Appetite - *recent* | |  | ☐ Diabetes |  | ☐ Chicken Pox |  |
| ☐ Ringing in Ear | |  | | ☑ Difficulty Swallowing | |  | ☐ Seizures |  | ☐ Polio |  |
| ☐ Ear Infections - *frequent* | |  | | ☐ Heatburn | |  | ☐ Thyroid Disease |  | ☐ Mumps |  |
| ☐ Dizzy Spells | |  | | ☐ Peptic Ulcer | |  | ☐ Stroke |  | ☐ Measles |  |
| ☐ Failing Vision | |  | | ☐ Persistent Nausea/Vomiting | |  | ☐ Tremor / Hands Shaking |  | ☐ German Measles |  |
| ☐ Fainting Spells | |  | | ☐ Abdominal Pain - *chronic* | |  | ☐ Muscle Weakness |  | ☐ Tuberculosis |  |
| ☐ Eye Pain | |  | | ☐ Gall Bladder Trouble | |  | ☐ Numbness/Tingling Sensations |  | ☐ Herpes |  |
| ☐ Double or Blurred Vision | |  | | ☐ Jaundice / Hepatitis | |  | ☐ Headaches – *frequent* |  | ☐ Alcohol oz per wk: # day | |
| ☐ Eye Infections- *frequent* | |  | | ☐ Change in Bowel Habits | |  | ☐ Arthritis / Rhumatism |  | ☐ Coffee / Tea  cups per day: Cups | |
| ☐ Nose Bleeds - *frequent* | |  | | ☐ Diarrhea | |  | ☐ Back Pain – *reccurent* |  |
| ☐ Sinus Trouble | |  | | ☐ Constipation | |  | ☐ Bone Fracture/Joint Injury |  | ☐ Smoking  Cig / day #day Years: yr | date |
| ☐ Sore Throats - *frequent* | |  | | ☐ Diverticulosis | |  | ☐ Gout |  |
| ☐ Hayfever / Allergies | |  | | ☐ Crohn's / Colitis | |  | ☐ Osteoporosis |  | **FEMALES** – *Please Complete* | |
| ☐ Hoarseness - *prolonged* | |  | | ☐ Bloody or Tarry Stools | |  | ☐ Foot Pain |  | **Menstrual Flow:**  Reg Irreg Pain/Cramps  Days / Flow # Length / Cycle Cups  1st day of last period date | |
| ☐ Pneumonia / Pleurisy | |  | | ☐ Hemorrhoids | |  | ☐ Cold Numb Feet |  |
| ☐ Bronchitis / Chronic Cough | |  | | ☐ Hernia | |  | ☐ Rashes |  |
| ☐ Asthma / Wheezing | |  | | ☐ Urine Infections - *frequent* | |  | ☐ Hives |  |
| ☐ Shortness of Breath:  ☐ On exertion ☐ lying flat | |  | | ☐ Blood in Urine | |  | ☐ Psoriasis |  | Number of:  Pregnancies # Abortions #  Miscarriages # Live Births # | |
| ☐ Kidney Stones | |  | ☐ Eczema |  |
| ☐ High Blood Pressure | |  | | ☐ Urination > 2x a night  ☐Painful ☐ Loss of Control ☐Decrease in Force / flow | |  | ☐ Sleeping – *difficulty* |  |
| ☐ Heart Murmur | |  | | ☐ Depression |  | Birth Control Method Method | |
| ☐ Irregular Pluse | |  | | ☐ Nervousness |  | B.C. Pill Name Pill Name | |
| ☐ Palpitations | |  | | ☐ Venereal Disease | |  | ☐ Memory Loss |  | Flushing / Menopause |  |
| ☐ Swollen Ankles | |  | | ☐ Chronic Fatigue | |  | ☐ Moodiness – *excessive* |  | Date of last PAP Test  Normal Abnormal | |
| ☐ Leg Pain – *when walking* | |  | | ☐ Weight Loss – *recent* | |  | ☐ Mental Illness |  |
| ☐ Varicose Veins / Phlebitis | |  | | ☐ Anemia | |  | ☐ Phobias |  | Date of last Mammogram  Normal Abnormal | |
| ☐ Cancer | |  | | ☐ Bruise Easily | |  | ☐ Scarlet Fever |  |
| ☐ Chest Pain | |  | | ☐ Rheumatic Fever | |  |  |  | Pain / Bleeding during or after sex | |
| SYNOPSIS | Enter Synopsis here | | | | | | | | | |
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