Past medical history

Different sources include different questions to be asked while conducting a past medical history, but in general, they include the following:

The general state of health: e.g. excellent, good, fair, poor. Note any significant change from the previous state.

Past illnesses

e.g. cancer, heart disease, hypertension, diabetes.

Hospitalizations

: including all medical, surgical, and psychiatric hospitalizations. Note the date, reason, duration for the hospitalization.

Injuries, or accidents

: note the type and date of injury.

Surgeries

: note the type of procedure, date, hospital, surgeon, and any complications.

Current medications

Note name, dosage, and frequency of any medication, including any over-the-counter medications and herbal remedies. Note whether patient is taking the medications according to the prescribed instructions.

Allergies

: note any environmental, food, or drug allergies, as well as the specific type of reaction, e.g. anaphylaxis, rash, itching.

Immunizations

: take a careful record of all immunizations, including tetanus, diphtheria, pertussis, polio, Hepatitis B, measles, mumps, rubella, Haemophilus influenzae type B, influenza.

Substance abuse

: note any alcohol, tobacco, and illicit drug use, include type, amount, and duration, as well as any past treatment or drug rehabilitation.

Diet

: ask about everything the patient has eaten the day before and for the past week. Note the type of food consumed and do a nutritional status assessment. Medically, however, this is considered to be a part of social history. Dietary supplements would also be under PMH.

Sleep

: a useful mnemonic for sleep patterns is BEARS, for Bedtime problems (e.g. snoring, sleep apnea, or nightmares), Excessive daytime sleepiness, Awakenings at night, Regularity and duration of sleep, Snoring.[2] Alternative therapies: e.g. acupuncture, massage, herbal medicine, vitamins, chiropractice.

Obstetric/Gynecologic history

(if female): include total number of pregnancies, whether they are full term, preterm, miscarriages, abortions, living, as well as any complications. Include menopause and date. Include sexual history and any history of sexually transmitted diseases.

Birth history

: details of labor and delivery of patient, admission to NICU, maternal fever, duration of rupture of membranes, Apgar scores (particularly import in first three months of life)

Growth and development

: plots of height, weight, and head circumference are standard content for pediatric records, any change in trajectory (e.g. growth plots which cross percentile lines rather than running parallel),

developmental mile stones, any IQ or other developmental testing