AKLILU & COBIAN INFECTIOUS DISEASES, LLC
PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REFERRING PHYSICIAN: _____ **PHYSICIAN TELEPHONE:** _____

REASON FOR VISIT: _____ **HIV POSITIVE SINCE:** _____

ALLERGIES: _____

CURRENT COMPLAINTS:

	YES	NO		YES	NO		YES	NO
Anxiety			Fatigue			Muscle Weakness		
Blood in Stool			Fever			Shortness of Breath		
Diarrhea			Headaches			Swollen Glands		
Dizziness / Fainting			Easy Bruising/Bleeding			Weakness		
Difficulty Swallowing			Incontinence			Other:		

PAST SURGICAL/PROCEDURE HISTORY:	Date	HOSPITALIZATIONS: (Please list)	Date
Colonoscopy			
Pap Smear			
Mammogram			
Other:			
Other:			
Other:			
Other:			

PAST MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO
Anemia			Hepatitis: (Circle) A B C			Pneumonia		
Anxiety			Herpes Simplex Virus			Pulmonary Tuberculosis		
Aspergillosis			High Cholesterol			Salmonella Bacteremia		
Candidiasis			Histoplasmosis			Sepsis		
Cancer Type:			HIV			Septic Arthritis		
Cardiomyopathy			Hypertension			Shingles		
Cryptococcosis			Kaposi Sarcoma			Sinusitis		
Cytomegalovirus			Lymphoma			Skin Infections		
Depression			Meningitis			Strongyloidiasis		
Diabetic			Mucormycosis			Syphilis		
Diarrhea			Recurrent Bacterial Infection			Thrombocytopenia		
Ear Infections			Mycobacterial Infection			Thrush		
Endocarditis			Nephropathy			Toxoplasmosis		
Epilepsy			Nocardiosis			Tuberculosis		
Esophagitis			Mental Illness			Tuberculosis Exposure		
GI Infections			Peripheral Neuropathy			Urinary Infections		
			PCP			Vaginal Yeast Infections		

Medication Name:	Dose:	How Many Times Daily:

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