

MEDICAL HISTORY – Page 1

Please take a few minutes to fill out our health history form. PLEASE fill in all areas, **FRONT AND BACK**, BEFORE YOUR APPOINTMENT. Your answers will help the provider plan and provide your care.

Name: _____ DOB: ____/____/____ Today's Date: ____/____/____

Pharmacy: _____ Pharmacy Location: _____

ADVANCE DIRECTIVES: Please check (√) all that apply

Do you have a Power of Attorney for health care? No Yes- Designated Individual: _____

Do you have a living will/Do not resuscitate? No Yes

Are you an organ donor? No Yes

Patient Care Team: Please answer each question.

Specialty:	Name/Group:	Last Visit Date:	Specialty:	Name/Group:	Last Visit Date:
OBGYN					
Eye Doctor					

CURRENT MEDICAL HISTORY: Please check (√) all that apply

<input type="checkbox"/> Addiction <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bipolar <input type="checkbox"/> Colon Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Reflux/GERD <input type="checkbox"/> Blood Clot <input type="checkbox"/> Heart Attack (MI)	<input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Hyperlipidemia (High Cholesterol) <input type="checkbox"/> Hypertension (High BP) <input type="checkbox"/> Irritable Bowel Syndrome (IBS) <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Migraine <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Skin Disease <input type="checkbox"/> TIA/CVA (Stroke) <input type="checkbox"/> Thyroid Disease	Are you currently under treatment/s for Cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ _____ _____ _____ <input type="checkbox"/> Other Mental Illness _____ _____ _____	Other: _____ _____ _____ _____ _____ _____ _____
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HOSPITALIZATIONS/SURGERIES: Please check (√) all that apply

<input type="checkbox"/> Appendectomy <input type="checkbox"/> Coronary Artery Bypass (Open Heart) <input type="checkbox"/> Carotid Endarterectomy <input type="checkbox"/> Cholecystectomy (Gallbladder) <input type="checkbox"/> Bariatric - (Gastric Bypass, Lap Banding)	<input type="checkbox"/> Hysterectomy(Partial or Total) <input type="checkbox"/> Nephrectomy <input type="checkbox"/> Splenectomy <input type="checkbox"/> Tonsillectomy, Adenoidectomy <input type="checkbox"/> COPD/ Emphysema	Other: _____ _____ _____ _____ _____
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FAMILY HISTORY: Please check &/or list all family members that apply

Illness	Relation to you
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____

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Name: _____ DOB: ____/____/____

Continuation - FAMILY HISTORY: *Please check &/or list all family members that apply*

Illness	Relation to you
<input type="checkbox"/> Cancer (what kind?) _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Cerebral Infarction (Stroke)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Dementia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Genetic Disease (sickle cell, cystic fibrosis)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Hyperlipidemia (High Cholesterol)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Heart Attack < 50 yrs	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Other: _____

SOCIAL HISTORY: *Check &/or answer each question.*

Tobacco Use:	<input type="checkbox"/> Current <input type="checkbox"/> Former (Quit Year _____) <input type="checkbox"/> Never <input type="checkbox"/> Exposure to Smoke <input type="checkbox"/> E-Cigs <input type="checkbox"/> Other _____	
Alcohol Use:	<input type="checkbox"/> Never drink <input type="checkbox"/> Occasional/social drinker <input type="checkbox"/> _____ # of drinks/day of alcohol	
Drug Use:	<input type="checkbox"/> None <input type="checkbox"/> Other use _____	
Caffeine Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes – How much? _____	
Exercise:	<input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Moderate	
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single # of Children? _____ # of Grandchildren? _____	Spouse's Name: _____
Living Arrangements:	<input type="checkbox"/> Independent - <input type="checkbox"/> Alone or <input type="checkbox"/> With Others <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> With Caregiver(s)	
Employment:	Current Job/Occupation? _____	
Sexually Active:	<input type="checkbox"/> No <input type="checkbox"/> Yes – with <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both # of _____ sexual partners	

WOMENS HEALTH HISTORY: *Check &/or answer each question.*

Age of first period: ____ yrs old	Has menopause started/occurred? <input type="checkbox"/> No <input type="checkbox"/> Yes- at age _____ yrs
Number of days between periods: _____	Number of days period lasts: _____ Flow is: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy
Number of: Total pregnancies: _____ Full term births: _____ Premature births: _____	Number of: Vaginal Births: _____
Miscarriages: _____ Abortions: _____	C-section: _____
Pregnancy Complications: <input type="checkbox"/> None <input type="checkbox"/> Yes- <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> other: _____	
Birth Control: <input type="checkbox"/> None <input type="checkbox"/> Birth control pill <input type="checkbox"/> DepoProvera <input type="checkbox"/> IUD <input type="checkbox"/> Partner-Vasectomy <input type="checkbox"/> Other _____	



MEDICAL HISTORY - Page 3

Name: _____ DOB: ____/____/____

ALLERGIES: List all allergies *and the type of reaction* (Ex: Sulfa- rash, Codeine- nausea, etc.)

Allergies	Type of Reactions
1.	
2.	
3.	
4.	

CURRENT MEDICATIONS: List all medications

Medicine	Over the Counter Vitamins/Supplements	Dosage	How often?	Provider
Ex: Lasix		20mg	Twice a day	Dr. Jones
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Immunizations: Please check (✓) all that apply ***Please bring in a copy of your immunization records**

Adult Vaccines	Administered Date	Adult Vaccines	Administered Date
<input type="checkbox"/> Tetanus		<input type="checkbox"/> Shingles	
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Flu Shot		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Hep B		<input type="checkbox"/> Other: _____	

PREVENTATIVE CARE: Please list the dates of your last test and results if known

Test	Date	Results
Mammogram		
Pap smear		
Colonoscopy		
AAA Screening (Abdominal Aortic Aneurysm)		

DEPRESSION SCREENING:

Over the past two weeks, I have had little interest or pleasure in doing things: No Yes
 Over the past two weeks I have felt down, depressed or hopeless: No Yes

