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*

□ Addiction	□ Hepatitis _____	Are you currently under	Other: _____
□ Anemia	□ Hyperlipidemia (High Cholesterol)	treatment/s for Cancer?	_____
□ Anxiety	□ Hypertension (High BP)	□ No □ Yes Type:_____	_____
□ Arthritis	□ Irritable Bowel Syndrome (IBS)	_____	_____
□ Asthma	□ Kidney Disease	_____	_____
□ Bipolar	□ Kidney Stones	_____	_____
□ Colon Disease	□ Liver Disease		_____
□ Congestive Heart Failure	□ Migraine	□ Other Mental Illness	_____
□ COPD/Emphysema	□ Osteoporosis	_____	_____
□ Dementia	□ Parkinson's Disease	_____	_____
□ Depression	□ Pulmonary Embolism	_____	_____
□ Diabetes Mellitus	□ Schizophrenia		_____
□ Enlarged Prostate	□ Seizures/Epilepsy	□ History of infections in the past	_____
□ Reflux/GERD	□ Skin Disease	_____	_____
□ Blood Clot	□ TIA/CVA (Stroke)	_____	_____
□ Heart Attack (MI)	□ Thyroid Disease	_____	_____

HOSPITALIZATIONS/SURGERIES: *Please check (√) all that apply*

□ Appendectomy	□ Hysterectomy(Partial or Total)	Other:_____
□ Coronary Artery Bypass (Open Heart)	□ Nephrectomy	_____
□ Carotid Endarterectomy	□ Splenectomy	_____
□ Cholecystectomy (Gallbladder)	□ Tonsillectomy, Adenoidectomy	_____
□ Bariatric - (Gastric Bypass, Lap Banding)	□ COPD/ Emphysema	_____

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

Illness	Relation to you
□ Alcoholism	□ Mother □ Father □ Sibling □ Child □ Other: _____
□ Anemia	□ Mother □ Father □ Sibling □ Child □ Other: _____
□ Asthma	□ Mother □ Father □ Sibling □ Child □ Other: _____
□ Blood Disorder	□ Mother □ Father □ Sibling □ Child □ Other: _____

MEDICAL HISTORY - Page 2

Name: _____ DOB: _____/_____/_____

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

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

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

Tobacco Use:	☐ Current ☐ Former (Quit Year _____) ☐ Never ☐ Exposure to Smoke ☐ E-Cigs ☐ Other _____	
Alcohol Use:	☐ Never drink ☐ Occasional/social drinker ☐ _____ # of drinks/day of alcohol	
Drug Use:	☐ None ☐ Other use _____	
Caffeine Use:	☐ No ☐ Yes – How much? _____	
Exercise:	☐ Sedentary ☐ Light ☐ Moderate	
Marital Status:	☐ Married ☐ Divorced ☐ Widowed ☐ Single # of Children? _____ # of Grandchildren? _____	Spouse's Name: _____
Living Arrangements:	☐ Independent - ☐ Alone or ☐ With Others ☐ Nursing Home ☐ Assisted Living Facility ☐ With Caregiver(s)	
Employment:	Current Job/Occupation? _____	
Sexually Active:	☐ No ☐ Yes – with ☐ Male ☐ Female ☐ Both # of _____ sexual partners	
Recent Travel History: (last 6 months)		

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

Age of first period: ____ yrs old	Has menopause started/occurred? ☐ No ☐ Yes- at age _____yrs
Number of days between periods: _____ Number of days period lasts: _____ Flow is: ☐ light ☐ moderate ☐ heavy	
Number of: Total pregnancies: ____ Full term births: ____ Premature births: ____ Miscarriages: _____ Abortions: _____	Number of : Vaginal Births: _____ C-section: _____
Pregnancy Complications: ☐ None ☐ Yes- ☐ High blood pressure ☐ Diabetes ☐ Pre-eclampsia ☐ other:_____	
Birth Control: ☐ None ☐ Birth control pill ☐ DepoProvera ☐ IUD ☐ Partner-Vasectomy ☐ 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
☐ Tetanus		☐ Shingles	
☐ Pneumonia		☐ Other:_____	
☐ Flu Shot		☐ Other:_____	
☐ Hep B		☐ 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

MEDICAL HISTORY Page 4

Name: _____ DOB: _____/_____/_____

REVIEW OF SYSTEMS: Check all that you are *currently* experiencing.

□ Feeling Tired or Poorly	□ Red Blood in Bowel Movement
□ Fever	□ Diarrhea
□ Chills	□ Constipation
□ Headache	□ Blood in Urine
□ Sinus Pain	□ Urinating frequently more than twice a night
□ Neck Symptoms	□ Urinary Loss of Control
□ Vision Problems	□ Pain During Urination
□ Earache	□ Pain in Flank
□ Nasal Symptoms	□ Vaginal Discharge
□ Sore throat	□ Musculoskeletal Symptoms
□ Chest pains or Discomfort	□ Soft Tissue Swelling
□ Palpitations	□ Localized soft tissue swelling in both legs
□ Difficulty Breathing	□ Motor Disturbances
□ Cough	□ Sensory Disturbances
□ Wheezing	□ Anxiety
□ Heartburn	□ Depression
□ Nausea	□ Insomnia
□ Vomiting	□ Skin Lesion
□ Abdominal pain	□ Skin: a rash
□ Black or Tarry Stools	

Additional information you would like to share with the provider:

_____
_____
_____
_____
_____
_____
_____
_____
_____