

MEDICAL HISTORY FORM  
PLEASE COMPLETE ALL 3 PAGES

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_ Race: \_\_\_\_\_ Alias: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cty: \_\_\_\_\_  
Phone-home: \_\_\_\_\_ Phone-work: \_\_\_\_\_  
Phone-cell: \_\_\_\_\_ Phone-other: \_\_\_\_\_  
Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date-of-Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Today's Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

Your answers on this form will help your physician understand your medical conditions better. Best estimates are fine if you cannot remember specific details. Thank You!

Alerts: \_\_\_\_\_ Advance Directives, Living Will, or POW: \_\_\_\_\_ Yes \_\_\_\_\_ No

ALLERGIES & REACTIONS: \_\_\_\_\_  
\_\_\_\_\_

Pharmacy Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How would you rate your general health? [circle one]    Excellent    Good    Fair    Poor

Present Health Concerns:

\_\_\_\_\_  
\_\_\_\_\_

Is this visit work related or MVA? \_\_\_\_\_ No    \_\_\_\_\_ Yes    If yes, date occurred? \_\_\_\_\_  
Explanation: \_\_\_\_\_  
\_\_\_\_\_

Medications and Dosage:

\_\_\_\_\_  
\_\_\_\_\_

Immunizations: [circle]

Hepatitis A    Hepatitis B    Tetanus Measles    Rubella    Varicella    Other \_\_\_\_\_

Personal Medical History: [please indicate whether you have had any of the following medical problems [with dates]

Heart attack _____	Bleeding _____	Blood transfusion _____
Heart disease _____	Cancer _____	Stroke _____
Hypertension _____	Depression _____	Alcoholism _____
High cholesterol _____	Diabetes _____	Other problems _____
Thyroid problem _____		
Specify type _____		

Surgical History: [please list all prior operations [with dates]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 Date-of-Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Family History: [please indicate the current status of your immediate biological family members]

	<u>Alive</u>	<u>Deceased</u>	<u>Age</u>	<u>Comments/Cause of death</u>
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Sister[s]: # _____	_____	_____	_____	_____
Brother[s]: # _____	_____	_____	_____	_____
Daughter[s]: # _____	_____	_____	_____	_____
Son[s]: # _____	_____	_____	_____	_____

Please indicate with a check [√] biological family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sis	Bro	Daug	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis	Mom's Bro	Dad's Sis	Dad's Bro
Alcoholism														
Anemia														
Arthritis														
Asthma														
Autoimmune														
Birth Defect														
Bleeding														
CA, Breast														
CA, Colon														
CA, Melanoma														
CA, Ovary														
CA, Prostate														
Depression														
Diabetes, Childhood														
Diabetes Type II														
Eczema														
Epilepsy Seizure[s]														
Food Allergies														
Genetic Diseases														
Hay Fever														
High Cholesterol														
High Blood Pressure														
Immuno Disorder														
Kidney Disease														
Mental Retardation														
Osteoporosis														
Substance Abuse														
Thyroid Disorders														
Tobacco Abuse														
Tuberculosis														
Other														
Other														

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Date-of-Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Social History:**

**Substance & Sexuality**

**Tobacco Use**

Cigarettes Never Quit: Date \_\_\_\_\_  
Current: packs/day \_\_\_\_\_ # of yrs \_\_\_\_\_  
Other Tobacco Use: \_\_\_\_\_  
Are you interested in quitting? No Yes

**Alcohol Use**

Do you drink alcohol? No Yes # drinks/wk \_\_\_\_\_  
Is alcohol use a concern for you or others? No Yes

**Drug Use**

Do you use any recreational drugs? No Yes  
Have you ever used needles? No Yes

**Sexual Activity**

Sexually Active? No Yes Not Currently  
Current sex partner[s] is/are male female  
Birth control method: \_\_\_\_\_ None needed  
Have you ever had any sexually transmitted diseases [STDs]? No Yes  
Are you interested in being screened for sexually transmitted diseases? No Yes

**Other Concerns**

**Caffeine Intake:** None Coffee/tea \_\_\_\_\_ cups/day  
Sodas \_\_\_\_\_ /day \_\_\_\_\_ Chocolate \_\_\_\_\_ oz/day

**Weight:** Are you satisfied with your weight? No Yes

**Diet:** How do you rate your diet? Good Fair Poor

Do you take supplements? \_\_\_\_\_

Do you drink 4 lg glasses of milk daily or take calcium supplements? No Yes

**Exercise:** Do you exercise regularly? No Yes

What kind of exercise? \_\_\_\_\_

How long? [minutes] \_\_\_\_\_ How often? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_

**Bike Helmet:** Do you use a bike helmet? No Yes

**Seat Belt:** Do you use seatbelts consistently? No Yes

Is **VIOLENCE** at home a concern for you? No Yes

Have you ever been abused? No Yes

Do you have a **GUN** in your home? No Yes

**Socialeconomics**

Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Years of Education/Highest Degree? \_\_\_\_\_  
Marital Status S M D W Other \_\_\_\_\_  
Spouse/Partner \_\_\_\_\_ Number of  
Children/Ages? \_\_\_\_\_ Who lives at home  
with you? \_\_\_\_\_

**Specialty History:** [for women]

Age at 1<sup>st</sup> period? \_\_\_\_\_  
Frequency of periods? \_\_\_\_\_ Length? \_\_\_\_\_  
Do you have any concerns about your period? No Yes  
Do you have any concerns about menopause? No Yes  
# of pregnancies? \_\_\_\_\_ # of deliveries? \_\_\_\_\_  
# of miscarriages? \_\_\_\_\_ # of abortions? \_\_\_\_\_

**REVIEW OF SYMPTOMS:**

Constitutional	Respiratory
_____ Fever/chills/sweats	_____ Cough/wheeze
_____ Weight loss/gain	_____ Breathing prob
_____ Change in energy	Cardiovascular
_____ Weakness	_____ Chest pain
_____ Excessive thirst	_____ Palpitations
_____ Urinary problems	
Eyes	Gastrointestinal
_____ Change in vision	_____ Abd. Pain
Ears/Nose/Throat	_____ Blood in bowel
_____ Difficulty in hearing	_____ Nausea
_____ Ringing in ears	_____ Vomiting
_____ Dental problems	Chest
_____ Hay fever/Allergies	_____ Breast lump
Genitourinary	_____ Nipple dischg
_____ Nighttime urination	Musculo-skeletal
_____ Leaking urine	_____ Muscle pain
_____ Unusual vag. bleeding	_____ Joint pain
_____ Dischg of penis/vagina	Skin
Blood/Lymphatic	_____ Rash
_____ Unexplained lumps	_____ Mole change
_____ Easy bruising/bleeding	Other
Neurological	_____ Sex Problems
_____ Headaches	Psychiatric
_____ Dizziness	_____ Anxiety/Stress
_____ Light-headedness	_____ Sleep problems
_____ Numbness	_____ Depression
_____ Memory loss	
_____ Loss of coordination	