Medical History

Full name:_____ Date of birth:_____ Date:_____

Primary doctor:_____

Doctor who requested today's visit: _____

List current/previous doctors and their specialty:_____

_____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control)

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ❑ Alcohol/Drug addiction
- ❑ Anemia
- ❑ Aneurysm
- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorder
- ❑ Blood clot
- ❑ Blood transfusion
- ❑ Cancer (type):
  - ❑ Breast ❑ Ovarian
  - ❑ Colon ❑ Uterine
  - ❑ _____
- ❑ Crohn's disease
- ❑ COPD/Emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Gout
- ❑ Hay fever
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Hepatitis B or C
- ❑ High cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Liver disease
- ❑ Seizure
- ❑ Sexually transmitted disease (type):
  _____
- ❑ Sickle cell disease
- ❑ Sleep apnea
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ (Positive) TB skin test
- ❑ Ulcerative colitis
- ❑ Other:_____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ❑ Adopted

Family Members		Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Mother				
Father				
Brothers and Sisters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			
Sons and Daughters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			

SOCIAL HISTORY

Occupation: Marital Status: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke? ❑ Yes ❑ No Packs per day: ❑ ¼ pack ❑ 1½ packs How many years?_____

Are you a former smoke? ❑ Yes ❑ No ❑ ½ pack ❑ 2 packs Year quit?_____

Do you chew tobacco? ❑ Yes ❑ No ❑ 1 pack ❑ Other:_____

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?

Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period:_____ Last pap smear:_____ Last mammogram:_____

Last colonoscopy:_____ Last prostate cancer screening:_____ Last bone density scan:_____

Immunizations: PPV23 / PCV13:_____ ❑ Flu:_____ ❑ TDaP:_____ ❑ COVID I & II:_____

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

❑ Weight gain	❑ Persistent cough	❑ Blood in stool	❑ Headaches
❑ Weight loss	❑ Chest discomfort	❑ Difficulty urinating	❑ Memory loss
❑ Night sweats	❑ Palpitations	❑ Trouble holding urine	❑ Numbness/Tingling
❑ Weakness	❑ Fainting	❑ Frequency of urination	❑ Tremor
❑ Fatigue	❑ Change in exercise tolerance	❑ Penis discharge	❑ Uncontrollable mood swings
❑ Insomnia	❑ Difficulty swallowing	❑ Vaginal discharge/bleeding	❑ Anxiety
❑ Change in hearing	❑ Indigestion or heartburn	❑ Nipple discharge	❑ Depression
❑ Change in vision	❑ Nausea	❑ Breast pain	❑ Skin Rash
❑ Runny nose	❑ Vomiting	❑ Breast lump	❑ Back pain
❑ Nose bleed	❑ Constipation	❑ Pain with intercourse	❑ Leg pain
❑ Fever	❑ Diarrhea	❑ Feeling too hot	❑ Leg swelling
❑ Blood in sputum	❑ Change in bowel habit	❑ Feeling too cold	❑ Other:_____
❑ Shortness of breath	❑ Blood in vomit	❑ Dizziness	

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

Patient/Designee signature | Patient name (**PRINT**) | Date | Time

Relationship to patient | Reason patient is unable to sign

Submit