Medical History (Please Print)

Please take a moment to fill out this medical history form so that your provider can get better acquainted with your medical needs. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

If you are new to this clinic, who was your previous primary care physician? ______________________________

Patient's Full Name: ____ Today's Date: __________________

DOB: ___________ Height: ______________________ Weight: _____________ Blood Type: _______________

Medication List

Start Date	Medication and Dose	Directions	Stop Date	Reason for Taking	Prescribed By

Past Medical History

1.) Please list any active medical problems for which you are currently being treated, such as hypertension, diabetes, high cholesterol, asthma and seizures.

____

____

2.) Please list your surgeries with date(s)

____

____

3.) Please list your non-surgical hospitalizations with date(s)

____

____

4.) Please list any major accidents or injuries with the date(s)

____

Prevention Information

Have you ever had (and date):

Flu Vaccine: __________________ Hep B Vaccine: __________________ Pneumonia Vaccine: _____________

Hep A Vaccine: _________________ Tetanus Vaccine: ________________ Gardasil Vaccine: _______________

Meningitis Vaccine: ________________________________ PPD/TB Test:______________________________

Do you use seat belts: Yes / No

Do you have smoke detectors in your home: Yes / No

Do you have a loaded firearm in your home: Yes / No If yes, how is it stored? ________________

Social History/Lifestyle

Where were you born and raised? ______________________ How long have you been in this area? ________

Do you still drive an automobile? Yes / No

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

If married, spouse's name: ____

Children(s) names and ages: ____

Who lives at home with you? ____

Your Occupation: ________________________________ Hobbies: __________________________________

Do you ride a motorcycle or bicycle? Yes / No Do you wear a helmet?: Yes / No

Do you smoke or use nicotine products? Yes / No Type: _______________ How many years:_______

Have you ever used recreational drugs? Yes / No Last usage date? __________ What kind?________

Do you take OTC medication such as aspirin, antacids, vitamins, etc? Yes / No

If yes, which ones and how often? ____________________________________

Do you take something to help you sleep? Yes / No If yes, what and how often? ___________________

Do you restrict your diet in any way? Yes / No If yes, how? ________________________________

Do you drink alcohol? [ ] Never [ ] Occasionally [ ] Daily How many drinks do you have when do drink___

Do you drink caffeine? Yes / No If yes, how much?_______________________________

Ever worked with chemicals, paint, asbestos or other hazardous material? Yes / No What kind____________

Family History

How many children do you have? [ ] None Sons: ________________ Daughters: _________________

Are all alive and in good health? Yes / No If no, please explain_________________________________

How many siblings do you have? [ ] None Brothers:________________ Sisters: _________________

Are they alive and well? Yes / No If no, please explain_______________________________________

Is your mother living? Yes / No If yes, major health problems / If no, cause of death:

Is your father living? Yes / No If yes, major health problems / If no, cause of death:

Is there a family history – father, mother, sister, brother, maternal/paternal grandparents of?

Relative:	Diabetes	Alcoholism	Drug Abuse	High Cholesterol	Suicide	Depression	Cancer (type)
Father							
Mother							
Sibling							
M. Grandmother							
P. Grandmother							
M. Grandfather							
P. Grandfather							
Other:							

Systems Review:

General- Have you noticed:

Significant weight change (> 10 lbs.) in the past 6 months Yes / No

Increase ______________ lbs. Decrease_____________ lbs.

Significant recent appetite change? Yes / No If yes, [ ] increase [ ] decrease

Significant sweating or night sweats Yes / No

Skin- Have you had:

Recent rashes, lumps, or other skin/hair/nail problems Yes / No If yes, explain: ___________________

A history of skin cancer? Yes / No

Eyes- Have you had:

Recent vision changes? Yes / No Last eye appointment: _____________ With whom:_____________

Glaucoma/Cataracts? Yes / No

Ears/Nose/Mouth/Throat- Have you had:
Hearing problems? Yes / No
Do you have/use hearing aides? Yes / No
Frequent wax impaction? Yes / No
Frequent nosebleeds? Yes / No
Do you have a history of Obstructive Sleep Apnea? Yes / No If yes, do you use a CPAP? Yes / No
Do you snore? Yes / No
Do you have excessive daytime fatigue? Yes / No
Do you notice significant dizziness and/or vertigo Yes / No

Cardiovascular- Do you get:
Chest pain/pressure/tightness/squeezing/discomfort? Yes / No
If yes, does it occur with activity or exertion? Yes / No
Heart fluttering/flip-flops/skipping or palpitations? Yes / No
Swelling ankles? Yes / No
Pain in legs while walking? Yes / No
Shortness of breath? Yes / No
Do you take antibiotics before dental work? Yes / No
Do you exercise on a regular basis? Yes / No How often? ___________ What type?_____________

Respiratory- Have you ever been told that you have:
Asthma? Yes / No
Emphysema/chronic bronchitis? Yes / No
Blood clots in your leg or lung? Yes / No
Tuberculosis(TB) or positive skin test? Yes / No
Do you notice frequent:
Wheezing/shortness of breath? Yes / No
Coughing / phlegm production? Yes / No
Coughing up blood? Yes / No

Gastrointestinal- Do you notice:
Frequent nausea of vomiting? Yes / No
Frequent diarrhea? Yes / No
Significant constipation? Yes / No
Bloody or black bowel movements? Yes / No
Frequent heartburn/indigestion? Yes / No
Do you take antacids? Yes / No If yes, how often? ______________
Trouble swallowing? Yes / No
Abdominal Pain? Yes / No
Have you ever been diagnosed with: [ ] ulcers [ ] hepatitis [ ] colitis
Have you ever had a colonoscopy? Yes / No If yes, when? _________________

Genitourinary- Do you notice:
Burning/frequency or hesitation with urination? Yes / No
Do you wake up in the night to urinate? Yes / No
Do you have difficulty starting your urine stream? Yes / No
Do you have problems holding your urine? Yes / No
Do you have to wear a pad for incontinence? Yes / No

Have you ever had kidney stones? Yes / No
Are you sexually active? Yes / No
Problems with your sex drive? Yes / No
Abnormal discharge? Yes / No
Have you ever at a sexually transmitted disease? Yes / No
What kind of birth control do you use? ____
Do you use condoms? [ ] Always [ ] Most of the time [ ] Rarely [ ] Never
Ever engaged in any activity to put you at risk for AIDS? Yes / No
Do you want an AIDS test? Yes / No
Have you ever been physically or sexually abused? Yes / No
If yes, would you like to discuss this further? Yes / No
Do you feel safe in your current home/environment? Yes / No

Women- Do you have or have you had?
Problems related to menopause? Yes / No
Prolonged or abnormal bleeding? Yes / No
Pelvic Pain? Yes / No
An abnormal pap smear? Yes / No
An abnormal mammogram? Yes / No
Breast discharge, masses or cancer? Yes / No
When was your last: Pap Smear?___________________ Mammogram?____________________
Do you perform self breast exams regularly? Yes / No
Number of pregnancies? _____________ Births? _________________ Miscarriages? ____________

Men-
Do you have difficulty with erections? Yes / No
Would you like to discuss this further? Yes / No

Musculoskeletal- Do you have or have you had?
Significant joint pain or arthritis? Yes / No
Gout? Yes / No
Neck pain? Yes / No
Back pain? Yes / No
Have you had a Bone Density Study? Yes / No If yes, when? _______________

Neurological- Do you have or have you had?
Tremors/shakes? Yes / No
Memory Problems? Yes / No
Seizures? Yes / No If yes, how often? _______________
A significant fall in the past year? Yes / No
Headaches? Yes / No
Blackouts/fainting spells? Yes / No
Numbness/tingling? Yes / No

Mental/Emotional-
In the past two weeks, have you felt down, depressed or hopeless? Yes / No
Have you recently had little interest of pleasure in your daily activities? Yes / No
Have you ever had depression so severe that you considered suicide? Yes / No

Do you feel that you worry excessively? Yes / No
Have you seen a psychiatrist/therapist in the past? Yes / No
If yes, when?___________ By whom?_________________

Hematological and Lymphatic- Have you had:
Anemia? Yes / No
Problems with your spleen? Yes / No
Bleeding or clotting problems? Yes / No
Easy bruising? Yes / No

Allergic/Immunologic- Have you had:
Seasonal allergies/hay fever? Yes / No If yes, what medicine do you take? _________________
Food allergies? Yes / No If yes, from what food? ___________________________
What type of reaction? _________________________
Latex or drug allergies? Yes / No If yes, from what drug? ___________________________
What type of reaction? _________________________

Have you seen an allergist? Yes / No If yes, when? _________ By whom?__________________

Do you have any other questions or concerns today?