FH Medical Care

Leading with Innovation

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Medical History

Name:		**Date:**	
Please briefly state the reason for your visit:			

Past Medical History –

Please check the box next to any conditions you currently are or have experienced:			
	Year Diagnosed		**Year Diagnosed**
❑ High Blood Pressure		❑ Cancer/Tumor	
❑ High Cholesterol		❑ Seizures/Epilepsy	
❑ Thyroid Disorder		❑ Heart Problems	
❑ COPD or Emphysema		❑ Depression or Anxiety	
❑ Asthma		❑ Psychiatric Disorder	
❑ Diabetes		❑ Other(s)	
❑ Kidney Disease			

Past Surgical Procedures /Hospitalizations /Serious Injuries or Fractures –

List history of any surgeries or injuries that may or may not have required hospitalization:			
Operation / Injury:	**Month/Year**	**Operation / Injury:**	**Month/Year**

Allergies (Food and Drug) –

List below any medications or foods causing an allergic reaction or intolerance (i.e., nausea):			
Food/Drug	**Reaction**	**Food/Drug**	**Reaction**

Current Medications /Vitamins /Herbal Supplements –

List any medications, drugs, vitamins and/or supplements you are currently taking/prescribed:					
Medication	**Strength**	**# of pills / frequency**	**Medication**	**Strength**	**# of pills / frequency**
ex: *Tylenol*	*500 mg*	*1 - twice daily*			

Social /Educational /Work History –

Please fill out the following information as accurately as possible:		
Marital Status: Single /Married /Divorced /Widowed	Age of children, if any:	
Work Status: Employed /Unemployed /Retired /Disabled	Current or Prior Occupation:	Hours worked per week:
What is your highest level of education?		
What type of exercises do you perform? Duration and frequency?		
In what type of residence do you live? (i.e., house, assisted living, apartment, etc.)		
On average, how many hours do you sleep per night?		
Do you consume caffeine? Yes / No	What kind of drink? Coffee /Tea /Soda	How many cups per day?
Do you drink alcohol? Yes / No	What type of alcohol?	Number of drinks per week?
Are you a current smoker? Yes / No	If you smoke, how many packs per day?	
Are you a former smoker? Yes / No	If so, what year did you quit?	Number of years you smoked?
Do you do any drugs? Yes / No	If so, please list what drugs and how often:	
Are you sexually active? Yes / No	Do you have sex with: Men / Women / Both	How many sexual partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

Family Health History –

Please list the health history of your blood/biological relatives:				
Relative	Living or Deceased	Current age or age of death	Cause of death	Health Problems (including any Chronic Conditions)
Father:				
Mother:				
Brother(s):				
Sister(s):				
Children:				

Disease Prevention /Diagnostic Studies /Health Maintenance –

Please enter the approximate dates of any immunizations or health screening tests:					
	Month/Year		**Month/Year**		**Month/Year**
Flu Vaccine		Measles [MMR] Vaccine		CAT Scan	
Pneumonia Vaccine		Meningococcal Vaccine		MRI Scan	
Tetanus Vaccine		AB Aneurysm Screen		Colonoscopy	
Hepatitis A Vaccine		Heart Catheterization		EKG	
Hepatitis B Vaccine		Heart Stress Test		Eye Exam	
Varicella Vaccine		Endoscopy		STD Test	
Shingles Vaccine		Bone Density		Pap Smear	
Gardasil Vaccine		Chest X-Ray		Mammogram	

Other Healthcare Providers –

List any other current or previous physicians you have seen in the last 5 years:		
Physician Name	**Specialty**	**Still seeing?**
		Y / N
		Y / N
		Y / N
		Y / N

Review of Systems –

Please review the following symptoms and check any of the items that relate to your health:			
General	**ENT**	**Respiratory**	**Cardiovascular**
❑ Headache	❑ Ear problems	❑ Asthma	❑ Chest pain
❑ Fever	❑ Eye problems	❑ COPD	❑ Heart problems
❑ Chills	❑ Nosebleeds	❑ Shortness of breath	❑ Heart murmur
❑ Fatigue	❑ Sore throat	❑ Wheezing	❑ Palpitations
❑ Weight loss	❑ Dry mouth	❑ Cough	❑ Irregular heartbeat
❑ Weight gain	❑ Snoring	❑ Sputum production	❑ Leg swelling

Gastrointestinal	**Genitourinary**	**Neurological**	**Psychiatric**
❑ Decreased appetite	❑ Blood in urine	❑ Loss of Balance	❑ Anxiety /Depression
❑ Diarrhea/blood in stool	❑ Difficulty urinating	❑ Coordination problems	❑ Mood swings
❑ Heart burn	❑ Frequent urination	❑ Difficulty speaking	❑ Substance abuse
❑ Nausea	❑ Kidney problems	❑ Dizziness	❑ Hallucinations
❑ Vomiting	❑ Painful urination	❑ Fainting	❑ Stressors
❑ Constipation	❑ Kidney stones	❑ Numbness/tingling	❑ Suicidal thoughts

By signing, I verify that the information provided is as accurate as possible. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

Patient Signature: ____ Date:_______________