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 treatment/s for Cancer?	Other: _____
☐ Anemia	☐ Hyperlipidemia (High Cholesterol)		
☐ Anxiety	☐ Hypertension (High BP)		
☐ Arthritis	☐ Irritable Bowel Syndrome (IBS)	☐ No ☐ Yes Type:_____	
☐ Asthma	☐ Kidney Disease		
☐ Bipolar	☐ Kidney Stones		
☐ Colon Disease	☐ Liver Disease		
☐ Congestive Heart Failure	☐ Migraine		
☐ COPD/Emphysema	☐ Osteoporosis		
☐ Dementia	☐ Parkinson's Disease	☐ Other Mental Illness	
☐ Depression	☐ Pulmonary Embolism		
☐ Diabetes Mellitus	☐ Schizophrenia		
☐ Enlarged Prostate	☐ Seizures/Epilepsy		
☐ 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	

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