PRIMARY CARE & MEDICAL NUTRITION CENTER

MEDICAL HISTORY FORM

Name: _____ **Age:** _____

Date of Last Physical: _____ **DOB:** _____

1. **Reason for visit/current health problems:** _____
   _____
   _____
2. **Significant health problems in the past including hospitalizations:** _____
   _____
3. **Surgeries:** _____
   _____
4. **Medications (prescription, non-prescription, and supplements):**

Name	Strength	Dose per day

5. **Allergies to medications or substances/specify reaction:** _____
   _____
6. **Family history:**

	Chronic medical illness
Father	
Mother	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Sister	
Brother	

7. **Social History:**

1. What is your diet? ☐ Regular _____ ☐ Vegetarian _____ ☐ Vegan _____
2. Do you get any regular exercise? For how long each time and how many days a week?

_____

3. What is your relationship status: Single Divorced Widowed Married Domestic partner
4. How many children do you have? _____
5. Are you currently employed: _____
6. What is your occupation: _____
7. Do you or have you ever smoked cigarettes, pipes, or cigar? How much? _____
8. Do you or have you ever used e-cigarettes or vape? _____
9. Do you drink alcohol? How many drinks per week? (One drink is equal to 2oz. of hard liquor, 4 oz. of wine, or 12oz. of beer) _____
10. Do you use any recreational drugs (e.g. Marijuana, cocaine, etc)? _____
11. Have you ever used recreational drugs intravenously? _____
12. What is your level of caffeine consumption? _____
13. Do you have an advanced directive? _____
14. Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?
    Not at all Only a little To some extent Rather much Very much
15. Do you wear seatbelts when driving or as a passenger in a car? _____
16. Do you see any other doctors regularly? _____
17. What is your sexual orientation: Straight or heterosexual Lesbian, gay or homosexual
    Bisexual Don't know Choose not to disclose
18. What is your sexual identity: Male Female Transgender male/female-to-male (FTM)
    Transgender female/male-to-female (MTF) Other Choose not to disclose

8. Mental Health History:

Feelings of depression/hopelessness/helplessness; Feelings of anxiety; Suicidal thoughts

_____

Name of Psychiatrist: _____
Psychiatric Diagnosis: _____

9. Preventive Care:

1) Date of last mammogram (women only): _____Result: _____
2) Date of last PAP (women only): _____Result: _____
3) Date of last DEXA scan (women only): _____Result: _____
4) Date of last screening colonoscopy (men & women): _____Result: _____
5) Vaccine dates: Tetanus: _____Flu: _____Pneumonia: _____
   Hepatitis: _____

Signature: _____ Date: _____