

Quality Care with a Personal Touch

MEDICAL HISTORY FORM - Page 2 of 2

Name: _____ Exercise: Type _____ min _____ x/week

Sleep: _____ hrs Seat belt: Y/N Tobacco/E-cig: _____ /day When started? _____ When quit? _____

Alcohol: _____ drinks/wk Drugs (including medical marijuana): _____ Aspirin: Y/N

Vaccinations: Last tetanus shot: _____ Pneumonia Vaccination: _____

CURRENT MEDICAL CONCERNS/QUESTIONS: _____

PLEASE CHECK ALL THAT APPLY

- weight gain
- weight loss
- fatigue
- fever
- night sweats

- visual difficulties
- hearing difficulties
- ear pain
- seasonal allergies
- dental problems

- chest discomfort
- rapid or irregular Heart Beat
- swelling in feet/legs

- cough
- wheezing
- Shortness of Breath
- snoring
- sleep apnea

- nausea
- vomiting
- diarrhea
- constipation
- abdominal pain
- change in stool
- blood in stool
- reflux/heartburn
- last colonoscopy/sigmoidoscopy _____

- urinary incontinence
- painful urination
- urinary urge/frequency
- blood in urine
- sexual difficulties

- new/changed headaches
- seizure
- dizziness
- passing out
- numbness/tingling
- tremor/shakiness
- memory loss
- weakness

- muscle pain
- joint pain

- easy bruising/bleeding
- swollen lymph nodes

- rash
- worrisome moles

- MEN:**
- penile discharge
- weakness of urinary stream
- nighttime urination
- number of children _____

- WOMEN:**
- pregnancies _____
- number of children _____
- number of miscarriages _____
- number of abortions _____
- painful/heavy periods
- irregular periods
- last mammogram _____
- last Pap _____
- menopausal symptoms
- breast lumps
- date of last menstrual period _____

- During the past month, have you often been bothered by ...feeling down, depressed, or hopeless?
- Yes
 - No
- ...little interest or pleasure in doing things?
- Yes
 - No
- suicidal thoughts
 - increased stress
 - difficulty sleeping
 - anxiety/nervousness
 - family/marital issues
 - pushed/shoved/harmed?
 - domestic violence

 - Advance Directives
 - Living Will
 - Power of Attorney

Personal goals for following year: _____

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