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MEDICAL HISTORY FORM - Page 1 of 2

Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Email: _____ Marital Status: _____

Employer: _____ Job: _____

Education Level: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Emergency Contact Phone: _____

FAMILY MEDICAL HISTORY				
	Yourself	Father	Mother	Siblings
High Blood Pressure				
High Cholesterol				
Diabetes				
Heart Disease/Heart Attack				
Cancer				
Lung Disease (Asthma/COPD)				
Thyroid Disease				
Autoimmune Disease				
Stroke				
Osteoporosis				
Alcoholism/Addiction				
Depression or Psychiatric Disease				
Other (specify):				
Check if Deceased >				

Medications and Dosages (including vitamins/herbs):

Specialists:

Drug Allergies: _____

Operations and Past Hospitalizations: _____

Please complete next side >>

Quality Care with a Personal Touch

Name: _____ DOB: _____ Date: _____

Exercise: Type _____ Min: _____ Per: Day / Week

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

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

Vaccinations: Date of last - Tetanus: _____ Pneumonia: _____ Shingles: _____

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 heartbeat
- ☐ 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: _____

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

- ☐ easy bruising/bleeding
- ☐ swollen lymph nodes
- ☐ blood clot

- ☐ 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 period _____

- ☐ muscle pain
- ☐ joint pain

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

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
- ☐ eating disorder

- ☐ advanced directives
- ☐ living will
- ☐ power of attorney

Personal goals for the following year: _____