Patient Medical History Form

Name: _____ Date of Birth: _____

Why are you seeing the Doctor today?: _____

Please list all testing, if any, that you have had regarding this condition:

_____

When did this condition first start?: _____

Do you have any allergies to any medications?: _____

The Medical Assistant will ask you for your medications once in exam room

What is the name and address of your preferred pharmacy?: _____

_____

Please check all that apply below:

Past Surgical History:

Appendectomy		Cosmetic surgery		Joint Replacement	
Brain surgery		C-section		Small intestine surgery	
Breast surgery		Eye surgery		Spine surgery	
Gallbladder		Fracture surgery		Tubal Ligation	
Colon surgery		Hernia repair		Valve replacement	
Vein ablation		Hysterectomy		Phlebectomy	

Other: _____

Medical Diagnosis:

Anemia		Emphysema		Nerve/ muscle disease	
Anxiety		GERD		Osteoperosis	
Arthritis		Glaucoma		Seizures	
Asthma		Heart Murmur		Sickle cell anemia	
Cancer		HIV/ AIDS		Stroke	
CHF		Hyperlipidemia		Substance abuse	
Clotting disorder		Hypertension		Thyroid disease	
COPD		Kindey Problems		Tuberculosis	
Depression		Meningitis		Ulcers	
Diabetes type 1		Heart Attack			
Diabetes type 2					

Other: _____

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Family Medical History:

Relationship	Alive or deceased	Substance Abuse	Cancer	COPD	Diabetes	Heart Attack	Heart Disease	High blood pressure	High cholesterol	Kidney Disease	Mental Retardation	Stoke	Depression
Mother													
Father													
Brother													
Sister													
Son													
Daughter													
Maternal Grandmother													
Maternal Grandfather													
Paternal Grandmother													
Paternal Grandfather													

Social History:

	Yes	No	# of years
Alcohol Use			
Drug Use			
Smoker			
Smokeless Tobacco			

Health Maintenance:

What is the date of your last Flu shot?_____

If over the age of 50, when was your last colonoscopy?:_____

If a women over the age of 40, when was your last mammogram?:_____

If over the age of 65, have you fallen in the last 3 months?:_____

Review of Systems:

Please check all that apply below:

Weight loss		Light sensitivity		Vomiting		**Neurological**	
Fatigue		Eye pain		Abdominal pain		Dizziness	
Sweating		Eye discharge		Diarrhea		Headaches	
Weakness		Eye redness		Constipation		Tingling	
Skin		**Cardiovascular**		Blood in stool		Tremor	
Rash		Chest pain		**GU**		Sensory change	
Itching		palpitations		Painful urination		Speech change	
HENT		Claudication		Urgency		Seizures	
Hearing loss		Leg swelling		Frequency		**Psychiatric**	
Tinnitus		**Respiratory**		Flank pain		Depression	
Ear pain		Cough		**Musculoskeletal**		Suicidal ideas	
Ear discharge		Shortness of breath		Neck pain		Substance abuse	
Nosebleeds		Wheezing		Back pain		Hallucinations	
Congestion				Joint pain		Nervous/anxious	
Sinus pain				Falls		Insomnia	
Sore throat						Memory loss	

Thank you for completing this form.

Please return completed paperwork to the front desk.