Patient Name:_____ DOB:_____Entered by:_____

Today's Date:_____

Medical History Form

Review of Systems

Are you experiencing any of the following symptoms?

General:
- ⌋ Allergies
- ⌋ Chills
- ⌋ Fatigue
- ⌋ Fever
- ⌋ Night Sweats
- ⌋ Weight Loss
- ⌋ Weight Gain

Skin:
- ⌋ Discoloration
- ⌋ Skin Lesions
- ⌋ Rash

HEENT:
- ⌋ Dizziness
- ⌋ Vision Changes
- ⌋ Hearing Problems
- ⌋ Ringing in the Ears
- ⌋ Nasal Congestion
- ⌋ Sinus Pressure
- ⌋ Snoring
- ⌋ Hoarseness
- ⌋ Sore Throat

Respiratory:
- ⌋ Asthma
- ⌋ Cough
- ⌋ Coughing Up Blood
- ⌋ Shortness of Breath
- ⌋ Wheezing

Cardiovascular:
- ⌋ Chest Pain
- ⌋ Difficulty Breathing on Exertion
- ⌋ Palpitations
- ⌋ Lower Extremities Swelling
- ⌋ Edema
- ⌋ Hypertension

Gastrointestinal:
- ⌋ Abdominal Pain
- ⌋ Acid Reflux
- ⌋ Constipation
- ⌋ Diarrhea
- ⌋ Difficulty Swallowing
- ⌋ Food Intolerance
- ⌋ Nausea
- ⌋ Vomiting

Genitourinary:
- ⌋ Blood in Urine
- ⌋ Frequency
- ⌋ Dysuria
- ⌋ Incontinence
- ⌋ Difficult Urination
- ⌋ Urgency

Musculoskeletal:
- ⌋ Back Pain
- ⌋ Joint Pain
- ⌋ Joint Stiffness
- ⌋ Muscle Pain
- ⌋ Muscle Weakness
- ⌋ Neck Pain
- ⌋ Neck Stiffness

Neurologic:
- ⌋ Headaches
- ⌋ Seizures
- ⌋ Syncope
- ⌋ Tingling
- ⌋ Tremor
- ⌋ Weakness

Psychiatric:
- ⌋ ADD
- ⌋ Anxiety
- ⌋ Bipolar
- ⌋ Depression
- ⌋ Trouble Focusing
- ⌋ Memory Loss
- ⌋ Sleep Disturbance

Endocrine:
- ⌋ Diabetes
- ⌋ Cold Intolerance
- ⌋ Thyroid Disease
- ⌋ Hormone Problems

Hematology:
- ⌋ Cancer
- ⌋ Lymphadenopathy
- ⌋ Anemia
- ⌋ Blood Clots

- ⌋ **Tobacco User**
- ⌋ **Former User**
- ⌋ **Never Smoker**

Patient Name:_____DOB:_____Entered by:_____

Past Medical History

Heart
- ⌋ Heart Attack
- ⌋ Heart Disease
- ⌋ High blood Pressure
- ⌋ High Cholesterol
- ⌋ Irregular Heart Beat
- ⌋ Atrial Fibrillation
- ⌋ Other_____

Lungs
- ⌋ Asthma
- ⌋ COPD
- ⌋ Emphysema
- ⌋ Other_____

Dermatology
- ⌋ Skin Cancer
- ⌋ Acne
- ⌋ Rash

Psychiatric
- ⌋ Memory Loss/Confusion
- ⌋ Anxiety
- ⌋ Depression
- ⌋ Bipolar

Stomach
- ⌋ Reflux
- ⌋ Heartburn
- ⌋ Ulcers
- ⌋ Bleeding
- ⌋ Irregular Bowel
- ⌋ Diverticulitis
- ⌋ Liver Disease
- ⌋ Hepatic Failure
- ⌋ Other_____

Musculoskeletal
- ⌋ Arthritis
- ⌋ Gout
- ⌋ Broken Bones
- ⌋ Other_____

Urology
- ⌋ Kidney Stones
- ⌋ Prostate Issues
- ⌋ Other_____

Other
- ⌋ Anemia
- ⌋ Sinus & Allergy
- ⌋ Other_____

Endocrine
- ⌋ Diabetes Type I
- ⌋ Diabetes Type II
- ⌋ Gestational Diabetes
- ⌋ Thyroid
- ⌋ Other_____

Neurologic
- ⌋ Stroke
- ⌋ Headache
- ⌋ Migraine
- ⌋ Dementia

Gynecology
- ⌋ Endometriosis
- ⌋ HPV

Cancer: List what type
_____
_____
_____

Social History

Tobacco:_____Never_____Quit: Year last smoked_____Amt:____pck/day Smoked for:_____years?
Do use a vape?_____yes_____no
Cigarettes____Yes_____No Amt:_____pck/day Has been smoking for?_____
Smokeless Tobacco _____Yes _____No Amt:_____per day
Cigars_____Yes_____No Amt:_____per day
Children: Secondhand smoke exposure?_____Yes_____No
Alcohol Use:_____Yes_____No_____# drinks per day / week / occasional / social
Caffeine Use:_____Yes_____No_____# drinks per day / week / occasional / social
Seatbelt Use: _____Yes_____No
Exercise:_____Yes_____No Occupation: _____
Have you ever used **street drugs**:_____Yes_____No Which ones:_____
Are you sexually active (in the last year?)_____Yes_____ No_____Never
If yes check all that apply:____1 Partner____Multiple Partner
_____Male Partner (s)_____Female Partner (s) _____5 or More Partners in your lifetime
Which birth control do you use?____None____Condoms____The Pill ___Vasectomy/Tubal____Other_____
Is there concern for your safety?____Yes____No____Emotional____Physical____Sexual Abuse

Patient Name:_____DOB:_____Entered by:_____

Current Medications: (Please include over the counter medication and food supplements.)

Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____
Drug Name:_____Dose:_____How Often:_____

⌋ NONE

Pregnancy and Birth

Date of Last Menstrual Period:_____ Age of First Period:_____
# of Days In Flow:_____# of Days Between Cycles:_____
Are you in Menopausal _____Age at Onset Of Menopause: _____
# of Pregnancies:_____# of Live Births:_____# of Abortions_____# of Miscarriages _____
# of Living Children _____

Past Surgical History

Please check or list all of the SURGERIES you have had:

Type of Surgery	Year
⌋ Appendectomy	
⌋ Arthroscopy (joint)	
⌋ Back Surgery or Neck Surgery	
⌋ Cataract Surgery	
⌋ Hemorrhoids	
⌋ Hernia (Specify)	
⌋ Hysterectomy	
⌋ Knee Replacement or Hip Replacement	
⌋ Mastectomy or Lumpectomy (Specify)	
⌋ Polyp Removal (Colon)	
⌋ Tonsillectomy or Adenoidectomy	
⌋ Tubal Ligation or Vasectomy	
⌋ Plastic Surgery (Specify)	
⌋ Other (Specify)	
⌋ Other (Specify)	
⌋ Other (Specify)	

Family History

⎦ Alcoholism	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Asthma	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Breast Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Colon Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Depression	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Diabetes	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Elevated Lipids	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Heart Attack	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Heart Disease	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ High Blood Pressure	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Lung Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Migraines	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Osteoporosis	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Ovarian Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Prostate Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Skin Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Stroke	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Thyroid Disease	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Uterine Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Other Cancer	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Other Diagnosis	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	
⎦ Other Mental Illness	⎦ Father	⎦ Mother	⎦ Sibling	⎦ Other_____	

List all **ALLERGIES** to any medications and the reactions:_____No Known Drug Allergies

Medication	Reaction

IMMUNIZATIONS: List Dates

Hepatitis A: _____

Hepatitis B: _____

Td– Adult Tetanus Toxoid : _____

Influenza:_____

Pneumovax:_____

PPD—Tuberculin Skin Test (Include Results):_____

Gardasil (HPV):_____

Zostavax:_____

Patient Name:_____DOB:_____Entered by:_____

Health Maintenance

Date of last Mammogram:_____(mo/yr) Date of last Done Density: _____(mo/yr)

Date of last Colonoscopy:_____(mo/yr)

(Diabetic Patients) Date of last Eye Exam:_____(mo/yr) Where: _____

For Women: Date of last Pap Smear:_____ (mo/yr)

For Men: Date of Last PSA level drawn (Prostate Cancer Screening):

_____

Please provide **first and last** names of all other physicians that you currently see and their specialty:

_____

_____

What is your preferred pharmacy (Please include name and phone number and location:

_____

What is your preferred mail order pharmacy (Please include name and phone number):

_____