Patient Medical History

Name: ______________________________________ Date of Birth: ____/____/____
FIRST MIDDLE LAST

Gender: ☐ Female ☐ Male ☐ Other: ____________

Reason for Today's Visit: ______________________________________

MEDICATIONS *(Including Over the Counter Medications, Vitamins, and Supplements)*

	Name	Dose	Directions		Name	Dose	Directions
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

ALLERGIES ☐ None

	Medication	Reaction
1.		
2.		
3.		

PAST MEDICAL HISTORY

Allergy/Dermatology
- ☐ Allergies
- ☐ Eczema
- ☐ Psoriasis
- ☐ Seborrheic Dermatitis/Dandruff

Cardiovascular
- ☐ Abnormal Heart Rhythm
- ☐ Abnormal Heart Valve
- ☐ Blood Clots in Legs
- ☐ Blockage of Carotid Artery
- ☐ Blockage of Coronary Artery
- ☐ Congestive Heart Failure (CHF)
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol/Triglycerides

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Pre-Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Gastrointestinal
- ☐ Acid Reflux/Heartburn/GERD
- ☐ Cirrhosis of the Liver
- ☐ Colon Polyps
- ☐ Crohns / Ulcerative Colitis
- ☐ Diverticulitis
- ☐ Gall Stones
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Ulcer

Hematologic
- ☐ Anemia (Low Blood Count)
- ☐ Bleeding Problems
- ☐ Clotting Problems (DVT)

Musculoskeletal
- ☐ Arthritis
- ☐ Fracture
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteopenia/Osteoporosis
- ☐ Rheumatoid Arthritis

Neurologic/Genetic
- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ CVA/Stroke
- ☐ Dementia
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Tension Headaches
- ☐ TIA
- ☐ Headaches

Pulmonary
- ☐ Asthma
- ☐ Blood Clot in Lung (PE)
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia (more than once)
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Tuberculosis

Renal/Genitourinary
- ☐ Endometriosis
- ☐ Erectile Dysfunction
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Recurrent UTI
- ☐ Prostate Enlargement (BPH)
- ☐ Urinary Incontinence

Mental Health
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Insomnia
- ☐ OCD
- ☐ Schizophrenia

Infectious Disease
- ☐ Hepatitis, type: ________
- ☐ Herpes (Cold Sores/Genital)
- ☐ HIV/AIDS
- ☐ COVID-19

Other Medical Conditions Not Listed: ______________________________________

____

SURGERIES and HOSPITALIZATIONS

Type:	Year:	Surgeon:

Colonoscopy: ____________________

MEDICAL CARE

List other providers participating in your medical care: ______________________________

Seen at an Urgent Care or Emergency Department recently? ☐ Yes ☐ No If yes, where: ____________

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WOMEN'S HEALTH

How many times Pregnant: _____ Deliveries #: ______ ☐ Vaginal ☐ C-section Complications: ______________________

Miscarriages: ____________ Abortions: __________ Pre-Term: ___________

Last Menstrual Period: _______________ Age of first Period: _________ Age of Menopause *(if applicable)*: ___________

Current Birth Control: ☐ Pills ☐ Patch ☐ Nuvaring ☐ Tubal Ligation ☐ Condoms ☐ Vasectomy in partner

☐ Nexplanon (date: ________) ☐ IUD (Mirena/Liletta/Kylena/Skyla/Paragard, date:_______) ☐ None

If none, would you like to discuss your options? ☐Yes ☐No

Gyn Surgeries (Hysterectomy, Ovary, etc.): ____

Last Pap Smear: ________________ Any Abnormal? ☐ Yes ☐ No If yes, describe: _____________________________

Last Mammogram: _______________ Any Abnormal? ☐ Yes ☐ No If yes, describe: _____________________________

Last Bone Density Scan: ___________ Any Abnormal? ☐ Yes ☐ No If yes, describe: _____________________________

SOCIAL HISTORY

Tobacco

Do you, or have you used Cigarettes, Pipe, Cigar, Snuff, or Chew? ☐ Yes ☐ No

Do you use now: ☐ Yes ☐ No

How many packs per day do/did you smoke? ____________ # of Years: _____ Year quit: _________

Do you use smokeless (chewing) tobacco now? ☐ Yes ☐ No

How much smokeless tobacco per day do/did you use? ____ # of Years: _____ Year quit: _________

Alcohol

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _______________________________

How many days per week do you drink? ______ How many drinks per day? _____________________

What is the greatest number of alcoholic beverages you will drink in a 24-hour period? ____________

Drugs

Do you or have you used Marijuana or recreational drugs (cocaine, amphetamine, heroin, etc.)?

☐ Yes ☐ No Current use: ____

Prior use: ____

Lifestyle

Occupation: _______________________________ Employer: _________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced Spouse's Name: _____________________________

Number of Children: ______________________ Ages: ____

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: ___________________

Religion/Church: _____________________________ Hobbies: _______________________________________

Exercise

Do you exercise regularly? ☐ Yes ☐ No Type of Exercise: __________________________________

How Long (minutes)? ______________________ How Often? _____________________________________

FAMILY MEDICAL HISTORY

Please also note the AGE at which they were affected

Illness/Condition	Grandmother	Grandfather	Mother	Father	Brother(s)	Sister(s)	Son(s)	Daughter(s)	None
Heart Attack									
Heart Failure (CHF)									
Diabetes									
Prostate Cancer									
Breast Cancer									
Colon Cancer									
Melanoma									
Dementia									
Mental Health Problems									
Alcohol Abuse									
Drug Abuse									
Suicide									
Other									

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete and accurate:

____ ______________________________

Name of the person completing this form Relationship to patient

____ ______________________________

Patient/Guardian Signature Date