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ERIN ROYAL MD
Healthcare for All Generations of Alaskans

PATIENT MEDICAL HISTORY

Name:_____ Date of Birth:_____/_____/_____ Gender: ☒ F ☐ M
FIRST MIDDLE LAST

Reason for Today's Visit:_____

MEDICATIONS *(Including Over the Counter Medications, Vitamins, and Herbal 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 /GERD
- ☐ Cirrhosis of the Liver
- ☐ Colon Polyps
- ☐ Crohn's Disease/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
- ☐ Obsessive-Compulsive Disorder
- ☐ Schizophrenia

Infectious Disease
- ☐ Hepatitis, type:_____
- ☐ Herpes (Cold Sores)
- ☐ Herpes (Genital)
- ☐ HIV/AIDS
- ☐ Syphilis

Other Medical Conditions Not Listed:_____

_____

SURGERIES and HOSPITALIZATIONS

Type:	Year:	Surgeon:

Colonoscopy?:

MEDICAL CARE

List other providers participating in your medical care:_____

Have you been 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 ☐Ring ☐Nexplanon ☐IUD (Mirena/Skyla/Paragard) ☐Tubal Ligation ☐Condoms
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 you/did you smoke?_____ # of years:_____ Year quit:_____
Do you use smokeless (chewing) tobacco now? ☐ Yes ☐ No
How much smokeless tobacco per day do you/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 most number of alcoholic beverages you will drink in a 24-hour period?_____

Drugs
Do you or have you used Marijuana or recreational drugs (cocaine, amphetamines, heroin, etc.)? ☐ Yes ☐ No
Current use:_____
Prior use:_____

Lifestyle
Occupation:_____ Employer:_____
Marital Status: ☐ Single ☐ Married ☐ Divorced Spouse's Name:_____
Number of Children:_____ Ages:_____
What is your 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 Disease/Heart Attack									
Diabetes									
Prostate Cancer									
Breast Cancer									
Colon Cancer									
Melanoma									
Alzheimer's/Dementia									
Mental Health Problems									
Alcohol/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, true and accurate:

_____ _____
Name of the person completing this form Relationship to patient

_____ _____
Patient/Guardian Signature Date