

Medical History Form

(This form is NOT to be used for OB/Gyn patients)

Basic Information

Date: _____

Name: _____

DOB: _____

Office Location: _____

List ALL current medications/herbal with directions and dosage of each listed:

List ALL allergies and types of reactions:

Current Medical History

Please check if applicable

- | | |
|--|---|
| <input type="checkbox"/> Healthy, No past/present medical problems | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Bone Fracture – Location _____ | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer – Type _____ | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Diabetes, Type 1 | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetes, Type 2 | <input type="checkbox"/> Motor Vehicle Accident with Injuries |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Recurrent Ear Infections |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Febrile Seizure | <input type="checkbox"/> UTI/Bladder Infection/Kidney Infection – Recurrent |
| <input type="checkbox"/> Gastroesophageal Reflux | |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> UTI/Bladder Infection/Kidney Infection – under age 5 years |

Past Surgical History

Please check if applicable

- | | |
|---|---|
| <input type="checkbox"/> No History of Previous Surgeries | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Abdominal Surgery – Type _____ | <input type="checkbox"/> Hernia Repair – Inguinal |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Hernia Repair – Umbilical |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Joint Replacement – Type _____ |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Joint Surgery – Type _____ |
| <input type="checkbox"/> Ear/Nose/Throat Surgery | <input type="checkbox"/> Kidney/Bladder Surgery |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Patent Ductus Arteriosus Repair |
| <input type="checkbox"/> Bladder Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Gynecological Surgery | <input type="checkbox"/> Vascular Surgery/Stent Procedure |
| <input type="checkbox"/> Other _____ | |

Family History

Please check if applicable

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Pancreatic Cancer |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Coronary Heart Disease Male under 55 | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Heart Disease Female under 65 | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Huntington's Chorea |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lung Cancer | |

Social History

Please complete the following questions

Pediatric (Newborn to 17 years old)

Parent/Guardian Name: _____

Siblings Names/DOB: _____

School Name: _____ Grade: _____

Has this child been exposed to any domestic violence? Yes No

Are there any religious beliefs that affect this child's care? Yes No

Is this child in foster care? Yes No

Are the parents of this child divorced or separated? Yes No

Does this child live with grandparents? Yes No

Was this child adopted? Yes No

Is this child exposed to ANY passive smoking? Yes No

Are this child's vaccines completely up to date? Yes No

If known please provide the following:

Birth Weight _____ Gestational Age _____

Pregnancy or Postnatal Complications _____

Adult (18 years old and up)

Marital Status: Single Married Separated Divorced

Number of Pregnancies _____ Number of Births _____

Occupation _____

Health Maintenance Form

Please supply most recent date for each of the following, if you have had them done in the past.

Please bring a copy of all shot records, test results, last EKG, etc. with you to your appointment. (If you have them)

Health Maintenance Value	Date Completed	Location Completed
Colonoscopy	_____	_____
EKG	_____	_____
Pap Smear	_____	_____
Physical Exam	_____	_____
Radiology		
Chest X-Ray	_____	_____
Mammogram	_____	_____
Vaccines		
Flu	_____	_____
Pneumonia	_____	_____
Shingles/Zostavax	_____	_____
Tetanus	_____	_____
Tetanus with Pertussis	_____	_____
Labs		
Cholesterol	_____	_____
Hgb A1c	_____	_____
PSA	_____	_____
Thyroid	_____	_____

Adult Risk Factors Questionnaire

Name: _____ Date of Birth: _____

Tobacco Use (All forms of tobacco):

Current Every Day User:

Cigarette Cigar Pipe Smokeless

#Packs per day _____ # years using _____ #Cans per day _____

Current Some Day User

Never Used

No Longer use Tobacco

Year Quit _____ #Packs per day _____ #years using _____

What type of tobacco did you use? _____

Passive exposure?/ Are you exposed to tobacco users? Yes No

Drug Use: Yes No

If yes list substance _____

Possible HIV Exposure: Yes No

Have you: Had more than 10 sexual partners in your life

Used IV drugs

Had a blood transfusion before 1987

Had exposure to someone with HIV

Caffeine Usage: # Drinks per day _____

Family History of Heart Attacks in females less than 65 years of age? Yes No

Family History of Heart Attacks in males less than 55 years of age? Yes No

Alcohol Use: Yes No

Drink Alcohol daily? Yes No

Drinks per day _____ Type of Alcohol _____

Have you ever felt the need to cut down?

Been annoyed by complaints of your drinking?

Felt guilty about your drinking?

Need an eye opener in the morning?

Exercise: Do you exercise: Yes No

What type of exercise? _____ # Times per week _____

Seat Belt Usage: Percent of time 100 75 50 25

Sun Exposure: Frequent Occasionally Rarely