Medical History Form

Known Medical Diagnosis: Please list your current or past diagnosis and year of diagnosis.

_____
_____
_____
_____
_____

What **Pharmacy** do you use? _____

Please list any **Medical Allergies and Reactions**:

_____
_____
_____

Medication List: Please list any medication and vitamins you are currently taking (or attach a current medication list): Example: Trazodone 50 mg, 1 every night

NAME OF MEDICATION	**DOSAGE (mg, mcg, etc.)**	**TIMES PER DAY (once/twice)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations (Please use the lines below to list.)

For children, please submit their vaccination record

	Last date received (month/year)	**Location (city/state)**
☐ Flu	_____	_____
☐ Pneumococcal	_____	_____
☐ Zostavax	_____	_____
☐ TDAP	_____	_____
☐ TD	_____	_____

My last Mammogram was in _____. (Please list the year) **WHERE:** _____

My last Pap Smear was in _____. (Please list the year) **WHERE**: _____

Date of Hysterectomy was _____.

Where was your Hysterectomy done (facility): _____.

Date of last Colonoscopy was _____.

Where was your last Colonoscopy done (facility): _____.

Date of last Sigmoidoscopy was _____.

Where was your last Sigmoidoscopy done (facility): _____.

Please place patient label here

Medical History Form

Surgical History

Mark any surgeries you have had and provide more details; circle what side of the body, if you had any implants and the date the surgery was done.

- ☐ Abdominal Surgery _____
- ☐ Ankle, Foot, Toe Surgery _____/**R or L**
- ☐ Appendectomy _____
- ☐ Back Surgery _____
- ☐ Biopsy (location) _____/**R or L**
- ☐ Breast Surgery _____
- ☐ Cataract Extraction _____
- ☐ Colonoscopy _____
- ☐ Coronary Bypass _____
- ☐ Coronary Stent _____
- ☐ EGD (Stomach Endoscopy) _____
- ☐ Gallbladder Removal _____
- ☐ Hand, Finger, Wrist Surgery _____/**R or L**
- ☐ Heart Surgery (other than Coronary Bypass) _____/_____
- ☐ Hernia Repair _____
- ☐ Hip Surgery _____**R or L**
- ☐ Hysterectomy (total) _____
- ☐ Hysterectomy (partial) _____
- ☐ Knee Surgery _____**R or L**
- ☐ LEEP (Cervix Surgery) _____
- ☐ Neck Surgery _____
- ☐ Ovary Removal _____
- ☐ Shoulder Surgery _____**R or L**
- ☐ Sigmoidoscopy _____
- ☐ Sinus Surgery _____
- ☐ Tonsillectomy _____
- ☐ Tonsils & Adenoids _____
- ☐ Tubal Ligation _____
- ☐ Vasectomy _____
- ☐ Other _____/_____
- ☐ Other _____/_____

In the last year have you referred yourself or been referred to any medical specialists? ☐ Yes ☐ No

If yes, please describe:_____

Social History

Alcohol Use

Do you drink alcohol? ☐ Currently ☐ In the past ☐ Never ☐ Beer ☐ Wine ☐ Liquor

Of drinks _____ per ☐ day ☐ week ☐ month.

Average drinks per episode last year: _____. Maximum drinks per episode last year: _____.

Please place patient label here

Tobacco Use

Tobacco use: ☐ Current every day ☐ Current some days ☐ In the past ☐ Never

Tobacco type: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ E-cigarettes

If current cigarette smoker: # of cigarettes per day _____ # of years smoked _____

If previous cigarette smoker: Quit date/age _____ # of years smoked _____

If current other tobacco: Number used per day _____ # of years used _____

If previous other tobacco: Quit date/age _____ # of years used _____

Substance Abuse

Have you used marijuana or recreational drugs? ☐ Currently ☐ In the past ☐ Never

If yes, please explain _____

Have you ever used needles to inject recreational drugs? ☐ Yes ☐ No

Employment Status

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Unemployed ☐ Retired/Date_____

☐ Student (If student what school are you attending) _____

Employer_____ Occupation _____

Employer's Address _____Work Number_____

Have you ever been exposed to any of the following?

☐ Hazardous Materials ☐ Heavy Lifting/Twisting ☐ Loud Noises ☐ Medical/Clinical Work

☐ Repetitive Motion ☐ Shift/Night Work ☐ Vibration ☐ Other_____

Home/Environment

Lives with _____ Living Situation ☐ Home/Independent ☐ Home with Assistance

☐ Nursing Home ☐ Hospice ☐ Assisted Living Facility ☐ Homeless/Shelter

Exercise

Do you exercise regularly? ☐ Yes ☐ No

Duration (average number of minutes): _____ Times Per Week: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Daily

Self-assessment: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

What type of exercise?

☐ Aerobics ☐ Organized team sport ☐ Swimming ☐ Weight Lifting

☐ Bicycling ☐ Running ☐ Walking ☐ Yoga

☐ Other: _____

Please place patient label here

Recent History (ROS) – Please helps us update any current concerns you may have. If no concern please select the no problem box.

General ☐ No Problems ☐ Appetite Loss ☐ Fatigue ☐ Fever ☐ Weakness ☐ Night Sweats ☐ Weight gain ☐ Weight loss ☐ Other	**Skin** ☐ No Problems ☐ Bruising ☐ Dryness ☐ Itching ☐ Skin Lesion ☐ Skin Rash ☐ Other _____	**Head or Neck** ☐ No Problems ☐ Dizziness ☐ Headache ☐ Neck Pain ☐ Syncope ☐ Other _____	**Eye** ☐ No Problems ☐ Blindness ☐ Blurring ☐ Double Vision ☐ Change in vision ☐ Red Eyes ☐ Other _____
Ears, Nose, Throat and Mouth ☐ No Problems ☐ Loss of Hearing ☐ Earache ☐ Nasal Congestion ☐ Sinus Pain ☐ Sore Throat ☐ Ringing in the ears ☐ Other _____	**Respiratory** ☐ No Problems ☐ Cough ☐ Short of breath ☐ Wheezing ☐ Other _____	**Cardiovascular** ☐ No Problems ☐ Chest pain ☐ Short of breath ☐ Palpitations ☐ Leg Swelling ☐ Other _____	**Gastrointestinal** ☐ No Problems ☐ Abdominal Pain ☐ Change in bowel habits ☐ Change in stool color ☐ Constipation ☐ Diarrhea ☐ Difficulty swallowing ☐ Blood in stool ☐ Nausea ☐ Vomiting ☐ Other _____
Breast ☐ No Problems ☐ Lump or mass ☐ Pain ☐ Nipple discharge ☐ Redness ☐ Other _____	**Gynecologic** ☐ No Problems ☐ Abnormal bleeding ☐ Vaginal discharge ☐ Other _____	**Genitourinary** ☐ No Problems ☐ Pain with urination ☐ Genital lesion ☐ Blood in urine ☐ Night time urination ☐ Other _____	**Endocrine** ☐ No Problems ☐ Change in heat ☐ Change in cold ☐ Diabetic ☐ Other _____
Musculoskeletal ☐ No Problems ☐ Back pain ☐ Joint pain/swelling ☐ Trauma ☐ Muscle aches ☐ Other _____	**Hematologic** ☐ No Problems ☐ Bleeding ☐ Bruising ☐ Other _____ **Lymphatic** ☐ No Problems ☐ Swollen lymph glands	**Neurologic** ☐ No Problems ☐ Altered sensation ☐ Memory loss ☐ Seizure ☐ Other	**Psychiatric** ☐ No Problems ☐ Anxiety ☐ Depression ☐ Decreased attention ☐ Eating disorder ☐ Sleeping problems ☐ Substance abuse ☐ Other

Please place patient label here

Family History- Indicate which relative has had the following diseases. If this was cause of death, please mark with a **C.** If you know the age of diagnosis please indicate that as well.

Disease	Mother	Father	Sister(s)	Brother(s)	Comments
Alcoholism					
Alzheimer / Dementia					
Asthma					
Autoimmune Disease					
Bleeding/Clotting Disorder					
Cancer Breast					
Cancer Colon					
Cancer Lung					
Cancer Ovarian					Type:
Cancer Prostate					
Cancer Other					
Colon Polyp					Age Found:
Coronary Artery Disease					
Depression					
Diabetes (adult onset)					
Diabetes (childhood onset)					
Drug Abuse					
Emphysema (COPD)					
Genetic Disorder					Explain:
Glaucoma					
Heart Attack					
Hepatitis					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease					
Migraine Headaches					
Osteoporosis					
Suicide					
Thyroid Disease					
Other:					
No significant history known					
Unknown					

Please place patient label here

Mother's age at time of death _____ Father's age at time of death _____

Patient Signature _____ Date _____

Reviewed _____

Physician Notes _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please place patient label here