

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

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

Immunizations (Please use the lines below to list.)

For children, please submit their vaccination record

	<u>Last date received (month/year)</u>	<u>Location (city/state)</u>
<input type="checkbox"/> Flu	_____	_____
<input type="checkbox"/> Pneumococcal	_____	_____
<input type="checkbox"/> Zostavax	_____	_____
<input type="checkbox"/> TDAP	_____	_____
<input type="checkbox"/> 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 _____ .

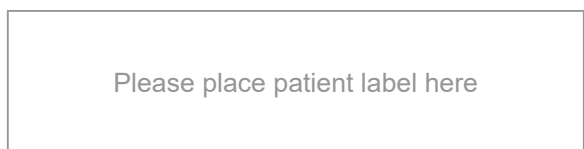
Where was your Hysterectomy done (facility): _____

Date of last Colonoscopy was _____ .

Where was your last Colonoscopy done (facility): _____

Date of last Sigmoidoscopy was _____ .

Where was your last Sigmoidoscopy done (facility): _____



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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.

- | | |
|--------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Abdominal Surgery _____ | <input type="checkbox"/> Hip Surgery _____ R or L |
| <input type="checkbox"/> Ankle, Foot, Toe Surgery _____ /R or L | <input type="checkbox"/> Hysterectomy (total) _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hysterectomy (partial) _____ |
| <input type="checkbox"/> Back Surgery _____ | <input type="checkbox"/> Knee Surgery _____ R or L |
| <input type="checkbox"/> Biopsy (location) _____ /R or L | <input type="checkbox"/> LEEP (Cervix Surgery) _____ |
| <input type="checkbox"/> Breast Surgery _____ | <input type="checkbox"/> Neck Surgery _____ |
| <input type="checkbox"/> Cataract Extraction _____ | <input type="checkbox"/> Ovary Removal _____ |
| <input type="checkbox"/> Colonoscopy _____ | <input type="checkbox"/> Shoulder Surgery _____ R or L |
| <input type="checkbox"/> Coronary Bypass _____ | <input type="checkbox"/> Sigmoidoscopy _____ |
| <input type="checkbox"/> Coronary Stent _____ | <input type="checkbox"/> Sinus Surgery _____ |
| <input type="checkbox"/> EGD (Stomach Endoscopy) _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Gallbladder Removal _____ | <input type="checkbox"/> Tonsils & Adenoids _____ |
| <input type="checkbox"/> Hand, Finger, Wrist Surgery _____ /R or L | <input type="checkbox"/> Tubal Ligation _____ |
| <input type="checkbox"/> Heart Surgery (other than Coronary Bypass)
_____ / _____ | <input type="checkbox"/> Vasectomy _____ |
| <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Other _____ / _____ |
| | <input type="checkbox"/> 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 help us update any current concerns you may have. If no concern please select the no problems box.

<p>General</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Appetite Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weakness <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Other_____	<p>Skin</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Bruising <input type="checkbox"/> Dryness <input type="checkbox"/> Itching <input type="checkbox"/> Skin Lesion <input type="checkbox"/> Skin Rash <input type="checkbox"/> Other_____	<p>Head or Neck</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Neck Pain <input type="checkbox"/> Syncope <input type="checkbox"/> Other_____	<p>Eye</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Blindness <input type="checkbox"/> Blurring <input type="checkbox"/> Double Vision <input type="checkbox"/> Change in vision <input type="checkbox"/> Red Eyes <input type="checkbox"/> Other_____
<p>Ears, Nose, Throat and Mouth</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Earache <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sore Throat <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Other_____	<p>Respiratory</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Cough <input type="checkbox"/> Short of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other_____	<p>Cardiovascular</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Chest pain <input type="checkbox"/> Short of breath <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Other_____	<p>Gastrointestinal</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Change in stool color <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Blood in stool <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other_____
<p>Breast</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Lump or mass <input type="checkbox"/> Pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Redness <input type="checkbox"/> Other_____	<p>Gynecologic</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other_____	<p>Genitourinary</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Pain with urination <input type="checkbox"/> Genital lesion <input type="checkbox"/> Blood in urine <input type="checkbox"/> Night time urination <input type="checkbox"/> Other_____	<p>Endocrine</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Change in heat <input type="checkbox"/> Change in cold <input type="checkbox"/> Diabetic <input type="checkbox"/> Other_____
<p>Musculoskeletal</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain/swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Muscle aches <input type="checkbox"/> Other_____	<p>Hematologic</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Other_____ <p>Lymphatic</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Swollen lymph glands	<p>Neurologic</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Altered sensation <input type="checkbox"/> Memory loss <input type="checkbox"/> Seizure <input type="checkbox"/> Other_____	<p>Psychiatric</p> <input type="checkbox"/> No Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Decreased attention <input type="checkbox"/> Eating disorder <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Substance abuse <input type="checkbox"/> 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
Coronary Artery Disease					
Heart Attack					
High Blood Pressure					
High Cholesterol					
Diabetes (childhood onset)					
Diabetes (adult onset)					
Thyroid Disease					
Glaucoma					
Liver Disease					
Kidney Disease					
Bleeding / Clotting Disorder					
Osteoporosis					
Alzheimer / Dementia					
Migraine					
Stroke / TIA					
Cancer Breast					
Cancer Colon					
Cancer Prostate					
Cancer Lung					
Cancer Ovarian					Type:
Cancer Other					
Alcohol Abuse					
Depression					
Drug Abuse					
Suicide					
Asthma					
Emphysema (COPD)					
Genetic Disorder					Explain:
Hepatitis					
Autoimmune Disease					
Colon Polyp					Age Found:
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 _____ Date: _____ Time: _____

Physician Notes _____

Please place patient label here