**Patient Name:** _____

**Date:** _____ **DOB:** _____ **Gender: M / F**

Medical & Patient History Form

## ****Please answer every question on both sides of this form****

**Please check conditions, which you have had in the past:**

**CVS**
- ○ Rheumatic Fever
- ○ High Cholesterol
- ○ Congestive Heart Failure
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Angina
- ○ Frequent Chest Pain
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Blood Clots in Veins
- ○ Blocked Arteries in Neck
- ○ Blocked Arteries in Legs

**Lymphatic / Hematologic**
- ○ Diabetes Mellitus
- ○ Overactive Thyroid
- ○ Underactive Thyroid
- ○ Anemia
- ○ Thyroid Goiter
- ○ Blood Transfusion

**Skin / Breast**
- ○ Acne
- ○ Eczema / Psoriasis
- ○ Fibrocystic Breast Disease
- ○ Abnormal Mammogram
- ○ Rashes
- ○ Hives
- ○ Moles

**Respiratory**
- ○ Sleep Apnea
- ○ Frequent Bronchitis
- ○ Emphysema
- ○ Pneumonia
- ○ Asthma
- ○ Clots in Lungs
- ○ Tuberculosis

**Musculoskeletal / Extremities**
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Joint Pain
- ○ Gout
- ○ Broken Bones
- ○ Osteoporosis
- ○ Osteopenia
- ○ Fibromyalgia
- ○ Neck Pain (hern. disc)
- ○ Back Pain (herniated disc)

**HEENT**
- ○ Glasses / Contacts
- ○ Glaucoma
- ○ Cataracts
- ○ Hearing Loss
- ○ Frequent Ear Infections
- ○ Ringing in Ears
- ○ Allergies
- ○ Frequent Sinus Infections
- ○ Mouth Sores

**Neurologic / Psychiatric**
- ○ Seizure
- ○ TIA
- ○ Stroke
- ○ Numbness
- ○ Weakness
- ○ Memory Loss
- ○ Migraine Headaches
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks
- ○ Suicide Attempt
- ○ Physical Abuse
- ○ Sexual Abuse
- ○ Mental Illness
- ○ Dizziness
- ○ Vertigo
- ○ Peripheral Nerve Disease
- ○ Insomnia

**General**
- ○ Abnormal Weight Loss
- ○ Abnormal Weight Gain
- ○ Cancer/Tumor _____

_____

_____# of Pregnancies

_____ Live Births

_____ Miscarriages

_____ Abortions

**GI /GU**
- ○ Heartburn
- ○ Stomach Ulcers
- ○ Gallstones
- ○ Blood in Stool
- ○ Hepatitis
- ○ Diarrhea / Constipation
- ○ Hemorrhoids
- ○ Abdominal Pain
- ○ Colon Polyps
- ○ Urinary Frequency
- ○ Bladder Infections
- ○ Prostate Disease
- ○ Urinary Incontinence
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Ulcerative Colitis
- ○ Crohn's Disease
- ○ Diverticulitis/Diverticulosis
- ○ Irritable Bowel Disease
- ○ Cirrhosis of the Liver
- ○ Liver Failure
- ○ Pancreatitis
- ○ Endometriosis
- ○ Abnormal PAP
- ○ Sex Transmitted Infection
- ○ HIV Infection

**Provider Notes:** _____

_____

**Please list any allergies or intolerance to drugs or other substances:** _____

_____

_____

**Please list the medications currently taken, their dosages, and how many times per day you take them:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Please indicate any surgeries you have had and the year you had them:**

| | | | |
|---|---|---|---|
| ○ Angioplasty _____ | ○ Trauma Related _____ | ○ Stomach _____ | ○ Tubal Ligation _____ |
| ○ Carotid Artery _____ | ○ Back/neck _____ | ○ Inguinal Hernia _____ | ○ C-Section _____ |
| ○ Other Vascular _____ | ○ Hip _____ | ○ Colonoscopy _____ | ○ Hysterectomy _____ |
| ○ Coronary Bypass _____ | ○ Knee _____ | ○ Gallbladder _____ | ○ Ovary Removed _____ |
| ○ Chest/Lung _____ | ○ Carpal Tunnel _____ | ○ Appendectomy _____ | ○ Breast _____ |
| ○ Tonsillectomy _____ | ○ Sinus _____ | ○ Prostate _____ | ○ Thyroid _____ |
| ○ Neurosurgery _____ | ○ Ear_____ | ○ Bladder _____ | ○ Other _____ |

**Provider Notes:** _____

**Please indicate when you last had any of the following preventative tests or services:**

| | | | |
|---|---|---|---|
| ○ Cardiac Angiogram _____ | ○ Flu Vaccine _____ | ○ PSA Blood Test _____ | ○ Colonoscopy _____ |
| ○ Stress Test _____ | ○ Pneumonia Vaccine ____ | ○ Rectal Exam _____ | ○ Mammo/Breast Exam ___ |
| ○ EKG _____ | ○ Tetanus Vaccine _____ | ○ Colon Cancer Stool Test __ | ○ PAP Smear _____ |
| ○ Chest X-Ray _____ | ○ Hepatitis Vaccine _____ | ○ Flexible Sigmoidoscopy ___ | ○ Last Menstrual Period ___ |
| ○ Echocardiogram _____ | ○ Bone Density Test _____ | ○ Barium Enema _____ | ○ Other _____ |

**Provider Notes:** _____

## Family Medical History

**Please check major illness in your family members (mother, father, brother, sister, or children)**

| | | | |
|---|---|---|---|
| ○ Tuberculosis | ○ Diabetes Mellitus | ○ Kidney Disease | ○ Breast Cancer |
| ○ Emphysema | ○ Thyroid Disease | ○ Epilepsy | ○ Ovarian Cancer |
| ○ Heart Disease | ○ Anemia | ○ Neurologic Disorder | ○ Colon Cancer |
| ○ High Blood Pressure | ○ Hemophilia | ○ Liver Disease | ○ Prostate Cancer |
| ○ Osteoporosis | ○ High Cholesterol | ○ Hepatitis | ○ Skin Cancer |

**Provider Notes:** _____

## Personal Information

**Marital Status:** ○ **Single** ○ **Married** ○ **Separated** ○ **Divorced** ○ **Widowed**

**What is or was your occupation?** _____

**Who is currently living in your home?** _____

**Have you ever felt threatened or do you currently feel threatened (emotionally/physically) in your home?** _____

**Risk Reduction:**

**Are you sexually active?** ○ **Not Active** ○ **Heterosexual** ○ **Homosexual** ○ **Bisexual**

**Do you or your partner use condoms (practice safe sex)?** ○ **Always** ○ **Never** ○ **Sometimes**

**Do you use tobacco products?** _____**If so, how much:** _____

**Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc.)?** _____

**How much alcohol do you consume weekly?** ○ **None** ○ **0 – 5** ○ **6 – 12** ○ **>12**

**Please indicate any of the following behaviors you follow:**

○ **Wear seatbelt** ○ **Wear helmet with bike / motorcycle** ○ **Gun in house** ○ **Gun secured**

○ **Fire extinguisher in house** ○ **Perform self breast** ○ **Perform self testicular exam** ○ **Smoke detector in house**

**What are your current dietary patterns?** _____

**Exercise on regular basis?** _____

**The information I have provided is true to the best of my knowledge.**

**Patient Signature:** _____ **Provider Signature:** _____ **MD**