Patient Name: _____ DOB: _____

Medical History Form

KNOWN MEDICAL DIAGNOSIS: Please list your current or past diagnosis and year of diagnosis (Eg. High blood pressure, chronic kidney disease, high cholesterol, asthma, heart attack, COPD, etc)

_____
_____
_____
_____
_____

MEDICATION ALLERGIES OR REACTIONS: (Example: Penicillin, rash)

_____
_____

PHARMACY: _____

MEDICATIONS: Please list any medications (including over the counter, supplements, herbs, and/or vitamins) you are currently taking (or attach a list):
Example: Trazodone 50 mg, 1 every night

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

_____
_____
_____
_____
_____

MEDICAL SUPPLIES OR EQUIPMENT: **SUPPLY COMPANY AND LOCATION:**
(Example: Glasses/contacts, hearing aids, dentures, oxygen, CPAP, cane, walker, wheelchair, etc.)

_____
_____
_____

MEDICAL SPECIALISTS (NAME AND LOCATION):

_____
_____
_____
_____

Preventative Health

List the location and date of any screening tests you have had done:

Service	Last date done (mo/yr), Location (city/state)
Cholesterol screening (lipid panel)	
Colon cancer screening ___Colonoscopy ___Sigmoidoscopy ___Cologuard ___FIT / Fecal Occult Blood Test (FOBT)	
Hepatitis B Screening Lab	
Hepatitis C screening Lab	
HIV screening	
Lung cancer screening (Low dose CT Scan)	
Sexually Transmitted Infections (STIs) Testing	
Diabetes screening (Fasting glucose, a1c)	
Osteoporosis screening (DEXA/ bone scan)	
Breast cancer screening (Mammogram)	
Cervical cancer screening (Pap smear)	
Abdominal Aortic Aneurysm Screening (AAA) Ultrasound or CT scan	
Prostate cancer screening (PSA blood test)	
Vaccinations	**Date(s) Completed**
Pneumonia (specify type) Prevnar (PCV) _13 _15 _20 __Pneumovax (PPSV) 23	
Hepatitis B series	
Influenza (Flu)	
Shingles (specify type) __Zostavax (1 dose series) __Shingrix (2 dose series)	
Tetanus (specify type) __Tdap __Td	
COVID-19 series (specify type) __Janssen __Pfizer # doses __Moderna # doses___	

Surgical History

Mark any surgeries you have had; **circle** side of the body, if you had any implants and the **surgery date**

☐Abdominal Surgery _____ ☐Ankle, Foot, Toe Surgery _____**/R or L**

☐Appendectomy _____
☐Back Surgery _____
☐Biopsy (location) _____/**R or L**
☐Breast Surgery _____
☐Cataract Extraction _____
☐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**
☐Sinus Surgery _____
☐Tonsillectomy _____
☐Tonsils & Adenoids _____
☐Tubal Ligation _____
☐ Vasectomy _____
☐Other _____/_____
☐Other _____/_____

Social History

Tobacco

Tobacco use: ☐Never ☐Current every day ☐Current some days ☐ Former ☐ Other: _____
Tobacco type: ☐Cigarettes ☐Cigar ☐Oral ☐Pipe ☐Other: _____
Starting date or age: _____ Average # per day or packs per day: _____
Quit date or age: _____ Total Number of years smoked: _____

Electronic Cigarette/Vaping

E-Cigarette Use: ☐Never ☐Use, within last 90 days ☐Former use, quit more than 90 days ago
Type**:** ☐Cannabinoid infused ☐Flavored only ☐Nicotine infused ☐Other: _____
Starting Date or age: _____ Quit date or age: _____

Alcohol

Alcohol Use: ☐Currently ☐In the past ☐Never
Type: ☐Beer ☐Wine ☐Liquor ☐Other: _____
Frequency: ☐1-2 a year ☐1-2 a month ☐ 1-2 a week ☐ Daily ☐ Several per day
Average drinks per episode last year: _____ Maximum drinks per episode last year: _____

Substance Use

☐Currently ☐In the past ☐Never
☐Amphetamines ☐Cocaine ☐Ecstasy ☐Hallucinogens/LSD ☐Heroin ☐Inhalants/Glues/Solvents
☐ Marijuana ☐Methamphetamines ☐Prescription medication ☐Other: _____
Frequency: ☐1-2 a year ☐1-2 a month ☐ 1-2 a week ☐ Daily ☐ Several per day
Have you ever used needles to inject recreational drugs? ☐Yes ☐No

Sexual

Sexually active: ☐Yes ☐No Since age: _____ Partners: ☐ Male ☐ Female ☐ Both ☐ Other: _____
Current Partners: ____ # of Lifetime Partners: ____ History of STIs: ☐ No ☐ Yes

Desire STI screening: ☐ Yes ☐ No
Use of condoms: ☐ Yes ☐ No Other contraception: _____
Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other_____
Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other _____

Nutritional/Health

Type of Diet: ☐ Regular ☐ Calorie Restricted ☐ Diabetic ☐ Vegetarian ☐ Vegan ☐ Other: _____
Do you have access or resources to access healthy food: ☐ Yes ☐ No
Desire to lose weight: ☐ Yes ☐ No History of eating disorder: ☐ Yes ☐ No Explain: _____
Sleeping Concerns: ☐ Yes ☐ No Caffeine intake: ☐ Yes ☐ No # per day: _____
High stress: ☐ Yes ☐ No

Home/Environment

Lives with: ☐ Alone ☐Children ☐Father ☐Mother ☐Sibling ☐Significant other ☐Spouse ☐Other: _____
Living Situation: ☐Home/Independent ☐Home with Assistance ☐Nursing Home ☐Hospice ☐Assisted
Living Facility ☐Homeless/Shelter ☐ Other: _____

Employment/School

☐Full Time ☐Part Time ☐Self Employed ☐Disabled ☐Unemployed ☐Retired/Date:_____
☐Student (If student, what school are you attending): _____
Occupation: _____
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: _____

Psychosocial

Religious preference: _____
History of abuse: ☐ Yes ☐ No

Exercise

Do you exercise regularly ☐Yes ☐No Self-assessment: ☐Poor ☐Fair ☐Good ☐Excellent
Duration (average # of minutes): _____ Times Per Week: ☐1-2 ☐3-4 ☐5-6 ☐Daily ☐Other: _____
What type of exercise?
☐ Walking ☐Aerobics ☐Running ☐Swimming ☐Weightlifting ☐Yoga ☐Other: _____

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest in doing things?	☐Not at all	☐Several days	☐More than half the days	☐Nearly every day
Feeling down, depressed or hopeless?	☐Not at all	☐Several days	☐More than half the days	☐Nearly every day

Recent History (ROS)

Please helps us update any current concerns you may have.

Patient Name: _____ DOB: _____

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 _____	**Endocrine** ☐ No Problems ☐ Change in heat ☐ Change in cold ☐ Diabetic 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 ☐ Nighttime urination ☐ Other ____	**Gastrointestinal** ☐ No Problems ☐ Abdominal Pain ☐ Change in bowel habits ☐ Change in stool color ☐ Constipation ☐ Diarrhea ☐ Difficulty swallowing ☐ Blood in stool ☐ Nausea ☐ Vomiting Other ____
Musculoskeletal ☐ No Problems ☐ Back pain ☐ Joint pain/swelling ☐ Trauma ☐ Muscle aches ☐ Other ____	**Hematologic** ☐ No Problems ☐ Bleeding ☐ Bruising ☐ Other _____ **Lymphatic** ☐ No Problems ☐ Swollen glands	**Neurologic** ☐ No Problems ☐ Altered sensation ☐ Memory loss ☐ Seizure ☐ Other	**Psychiatric** ☐ No Problems ☐ Anxiety ☐ Depression ☐ Decreased attention ☐ Eating disorder ☐ Sleeping problems ☐ Substance abuse ☐ Other

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 or death, please indicate that as well.

Patient Name: _____ DOB: _____

Disease	Father	Mother	Brother(s)	Sister(s)	Comments
No known significant history					
Unknown					
Alcohol abuse					
Alzheimer / Dementia					
Asthma					
Autoimmune Disease					
Cancer: ☐ Breast age diagnosed _____ ☐ Colon age_____ ☐ Lung age_____ ☐ Ovarian age_____ ☐ Prostate age_____ ☐Other _____					
COPD					
Coronary Artery Disease					
Depression					
Diabetes Type 1 (childhood onset)					
Diabetes Type 2 (adult onset)					
Drug Abuse					
Genetic Disorder/Carrier					
Glaucoma					
Heart Attack					
Hepatitis					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease					
Migraine					
Osteoporosis					
Polyp of Colon					
Suicide					
Thyroid Disease					
Other:					

Patient Name (printed) _____

Patient Signature _____ **Date** _____

patient label

Reviewed _____

Physician Notes

_____

_____

_____