

Patient Name: _____

Date: _____ DOB: _____ Gender: M / F

Medical/Personal History

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

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

- | | | | |
|--|--|--|--|
| <p>CVS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Angina <input type="checkbox"/> Frequent Chest Pain <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Valve Disease <input type="checkbox"/> Blood Clots in Veins <input type="checkbox"/> Blocked Arteries in Neck <input type="checkbox"/> Blocked Arteries in Legs <p>Lymphatic / Hematologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Overactive Thyroid <input type="checkbox"/> Underactive Thyroid <input type="checkbox"/> Anemia <input type="checkbox"/> Thyroid Goiter <input type="checkbox"/> Blood Transfusion <p>Skin / Breast</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acne <input type="checkbox"/> Eczema / Psoriasis <input type="checkbox"/> Fibrocystic Breast Disease <input type="checkbox"/> Abnormal Mammogram <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Moles | <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Frequent Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Clots in Lungs <input type="checkbox"/> Tuberculosis <p>Musculoskeletal / Extremities</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Gout <input type="checkbox"/> Broken Bones <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Neck Pain (hern. disc) <input type="checkbox"/> Back Pain (herniated disc) <p>HEENT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Sinus Infections <input type="checkbox"/> Mouth Sores | <p>Neurologic / Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizure <input type="checkbox"/> TIA <input type="checkbox"/> Stroke <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Memory Loss <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Mental Illness <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> Peripheral Nerve Disease <input type="checkbox"/> Insomnia <p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal Weight Loss <input type="checkbox"/> Abnormal Weight Gain <input type="checkbox"/> Cancer/Tumor _____ _____ _____ # of Pregnancies _____ Live Births _____ Miscarriages _____ Abortions | <p>GI /GU</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Gallstones <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Hepatitis <input type="checkbox"/> Diarrhea / Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Diverticulitis/Diverticulosis <input type="checkbox"/> Irritable Bowel Disease <input type="checkbox"/> Cirrhosis of the Liver <input type="checkbox"/> Liver Failure <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Endometriosis <input type="checkbox"/> Abnormal PAP <input type="checkbox"/> Sex Transmitted Infection <input type="checkbox"/> 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 _____
- Carotid Artery _____
- Other Vascular _____
- Coronary Bypass _____
- Chest/Lung _____
- Tonsillectomy _____
- Neurosurgery _____
- Trauma Related _____
- Back/neck _____
- Hip _____
- Knee _____
- Carpal Tunnel _____
- Sinus _____
- Ear _____
- Stomach _____
- Inguinal Hernia _____
- Colonoscopy _____
- Gallbladder _____
- Appendectomy _____
- Prostate _____
- Bladder _____
- Tubal Ligation _____
- C-Section _____
- Hysterectomy _____
- Ovary Removed _____
- Breast _____
- Thyroid _____
- Other _____

Provider Notes: _____

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

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

Provider Notes: _____

Family Medical History

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

- Tuberculosis
- Emphysema
- Heart Disease
- High Blood Pressure
- Osteoporosis
- Diabetes Mellitus
- Thyroid Disease
- Anemia
- Hemophilia
- High Cholesterol
- Kidney Disease
- Epilepsy
- Neurologic Disorder
- Liver Disease
- Hepatitis
- Breast Cancer
- Ovarian Cancer
- Colon Cancer
- Prostate Cancer
- 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
- Fire extinguisher in house
- Perform self breast
- Perform self testicular exam
- Smoke detector in house
- Wear helmet with bike / motorcycle
- Gun in house
- Gun secured

What are your current dietary patterns? _____

Exercise on regular basis? _____

Patient Signature: _____ **Provider Signature:** _____ **MD/DO/PA-C**