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PATIENT MEDICAL HISTORY

LAST NAME	FIRST NAME	DATE OF BIRTH	TODAY'S DATE

Why are you seeing us today? _____

What are your expectations for today's visit? _____

Current Medications

Please list ALL medications you are currently taking, including over-the-counter medications/supplements – Use addiional paper if necessary.

Drug Name	Strength/Dose	Directions/How you take it

Allergies

Please list ALL types of allergies – drug, seasonal, pets, environmental, foods – especially **Peanut** and **Latex** allergies.

Past Medical History

Last Colonoscopy/Sigmoidoscopy _____ Polyps? _____ Last Bloodwork _____

Last PAP _____ Abnormal? _____ Last Physical _____ Last Mammogram _____

Have you ever been checked for Infectious Hepatitis? ☐ No ☐ Yes

Please Check the Box if you **have** or **ever had** any of the following diseases or conditions:

Cardiovascular
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artey Disease (CAD)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Stents
- ☐ Bypass
- ☐ Clotting Disorder
- ☐ Blood Transfusion

Endocrine/Metabolic
- ☐ Diabetes Mellitus
- ☐ Hyperthyroidism/Hypothyroidism
- ☐ Insulin Resistance

Infectious Disease
- ☐ Hepatitis (type _____)
- ☐ Sexually Transmitted Infection
- ☐ HIV
- ☐ Tuberculosis

GI
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Chronic Diarrhea
- ☐ Diverticulitis
- ☐ GERD/Heartburn
- ☐ Liver Failure/Hepatitis
- ☐ Pancreatitis
- ☐ Trouble Swallowing

GU
- ☐ Bladder/Kidney Stone
- ☐ Erectile Dysfunction
- ☐ Kidney Failure
- ☐ Interstitial Cystitis
- ☐ Neurogenic Bladder
- ☐ Recurrent Urinary Tract Infections

GYN/OB
- ☐ Endometriosis
- ☐ Menopause/Painful Intercourse
- ☐ Osteoporosis
- ☐ Uterine Fibroids
- ☐ PCOS

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Reactive Airway
- ☐ Chronic Cough
- ☐ Sleep Apnea

Musculoskeletal
- ☐ Arthritis
- ☐ Chronic Back Pain
- ☐ Fibromyalgia
- ☐ Knee/Hip Surgery

Neurological/Psychological
- ☐ Neuropathy
- ☐ Stroke
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Suicide Attempts
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Other Mental Health Diagnosis

HEENT
- ☐ Blindness/Vision Impairment
- ☐ Deafness/Hearing Impairment
- ☐ Glaucoma
- ☐ Chronic Sinusitis
- ☐ Recurrent Tonsilitis
- ☐ Wax Impaction

Dermatological/Skin
- ☐ Skin Tags
- ☐ Skin Rash/Discoloration
- ☐ Changing Moles
- ☐ Keratosis
- ☐ Mole Removal
- ☐ Melanoma _____

- ☐ **Cancer**
- ☐ **Autoimmune Disorders**
- ☐ **Radiation/Nuclear Exposure**
- ☐ **Sexual/Physical/Verbal Abuse**

Other _____

Surgical History

Please list any surgeries you have had including the date of surgery:

_____

_____

_____

Family History

Please list the family members that have or have had any of the following: (i.e., Mother, Father, Grandparents, Siblings, Aunt, Uncle, etc.)

Breast Cancer _____ **High Blood Pressure** _____

Cervical/Uterine Cancer _____ **High Cholesterol** _____

Prostate Cancer _____ **Stroke** _____

Colon Cancer _____ **Blood Disorders** _____

Kidney Disease _____ **Seizure Disorders** _____

Diabetes/Insulin Resistance _____ **Mental Illness** _____

Other _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____ Spouse's Name _____

Number of Children _____ Year of Birth(s) _____

Occupation _____ Place of Employment _____

Alcohol Consumption: ☐ No ☐ Yes Number of Drinks per day/week/month/year (circle one) _____

Tobacco/Vape Use: ☐ No ☐ Yes Number of Packs per Day _____ Cigarettes per Day _____ Smokeless Tobacco _____ Cigars _____

Duration: _____ If you previously smoked, when did you quit? _____

Recreational Drugs: ☐ No ☐ Yes If Yes, please list _____

Caffeinated Beverages: ☐ No ☐ Yes If Yes, please list _____

Recent Foreign Travel: ☐ No ☐ Yes Where to or from? _____

Review of Systems

Are you currently having:

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Insomnia

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting

Musculoskeletal
- ☐ Back Pain
- ☐ Gout
- ☐ Joint Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Neck Pain/Stiffness

Endocrine
- ☐ Excessive Thirst
- ☐ Tired/Sluggish
- ☐ Swollen Glands
- ☐ Too Hot/Too Cold

Respiratory
- ☐ Asthma
- ☐ Enviromental Allergies
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Neurological
- ☐ Headaches
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Depression/Anxiety

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Swelling

Pain
- ☐ Severity _____
- ☐ Location _____

Skin
- ☐ Changing Moles
- ☐ Persistent Itch
- ☐ Skin Rash
- ☐ Skin Tags

Ear/Nose/Throat
- ☐ Sinus Problem
- ☐ Sore Throat
- ☐ Ear Pain/Ear Wax Impaction

Other _____

_____

If you are here for hormone replacement therapy, please ask for an additional evaluation form. Thank you!