

MEDICAL HISTORY – Page 1

	minutes to fill out o Your answers will		-			as, FRONT	AND BACK	X, BEFORE YOUR		
Name:		DOB:		//		Today's I	Date:	//		
Pharmacy:			Pharmacy Location:							
ADVANCE DI	RECTIVES:. Plea	se check (√) all 1	hat apply	V						
	Power of Attorney for				Designated I	ndividual:				
	iving will/Do not re				ocsignated in	ildividuai				
•	$\frac{1}{1}$ n donor? \square No		.10 🗆 .	1 03						
Ale you all orga	iii dolloi ! 🗆 No	1 68								
Patient Care T	eam: Please answer	each question.								
Specialty:	Name/Group:	<u> </u>		Special	tv:	Name/Group:		Last Visit Date:		
OBGYN	T turner Group:	<u> </u>	Last Visit Date.		~postattj.		щр.	East Visit Butc.		
Eye Doctor										
Lyc Doctor										
CUDDENT M	EDICAL HISTOR	V. Plagga ahaa	k (2) all s	that apply						
□ Addiction	EDICAL HISTOR		κ (<i>v) αιι ι</i>	пан аррну	Ama viau aumm	antly under	Othor			
☐ Addiction ☐ Anemia		□ Hepatitis			,			:		
	☐ Hyperlipidemia (High Cholesterol)			treatment/s for Cancer?						
□ Anxiety □ Arthritis		☐ Hypertension (High BP) ☐ Irritable Bowel Syndrome (IBS)			□ No □ Yes Type:					
□ Asthma		☐ Kidney Disease								
□ Astnma □ Bipolar		☐ Kidney Stones								
□ Colon Disease		☐ Liver Disease								
□ Congestive Heart Failure		☐ Migraine								
□ COPD/Emphysema		□ Osteoporosis								
□ Dementia		□ Parkinson's Disease			□ Other Mental Illness					
□ Depression		□ Pulmonary Embolism								
□ Diabetes Mellitus		□ Schizophrenia								
□ Enlarged Prostate		□ Seizures/Epilepsy								
□ Reflux/GERD		□ Skin Disease								
□ Blood Clot		□ TIA/CVA (Stroke)								
☐ Heart Attack (MI	()	☐ Thyroid Disea	se							
HOSPITALIZA	ATIONS/SURGER	RIES: Please c	heck $()$ d	all that appl	y					
□ Appendectomy		☐ Hysterectomy(Partial or Total)			Other:					
☐ Coronary Artery Bypass (Open Heart)		□ Nephrectomy								
□ Carotid Endarterectomy		□ Splenectomy								
☐ Cholecystectomy (Gallbladder)		☐ Tonsillectomy, Adenoidectomy								
□ Bariatric -		□ COPD/ Emphysema								
(Gastric Bypass, I	Lap Banding)									
FAMILY HIST	TORY: Please check	k &/or list all fa	mily mem	ibers that a	oply					
Illness		F	tion to y							
□ Alcoholism		☐ Mother ☐ Father			☐ Child	☐ Other:				
☐ Anemia		☐ Mother ☐ Father			☐ Sibling ☐ Sibling		Other:			
☐ Asthma			☐ Father		☐ Child	Other: _				
☐ Blood Disorder		\square Mo	other	\square Father	\square Sibling	\square Child	\square Other: _			



MEDICAL HISTORY - Page 2 DOB: Name: **Continuation - FAMILY HISTORY:** Please check &/or list all family members that apply Illness Relation to you ☐ Cancer (what kind?) _ \square Mother \square Father \square Sibling \square Child ☐ Other: ☐ Cerebral Infarction (Stroke) \square Mother \Box Father \Box Sibling ☐ Child \square Other: ☐ Dementia \square Mother \square Father \square Sibling \square Child \square Other: ☐ Diabetes \square Mother \square Father \square Sibling \square Child \square Other: ☐ Genetic Disease (sickle cell, cystic fibrosis) \square Mother \square Father \square Sibling \square Child \square Other: ☐ Heart Disease \square Mother \square Father \square Sibling \square Child \square Other: ☐ Hyperlipidemia (High Cholesterol) \square Mother \square Father \square Sibling \square Child ☐ Other: ☐ Hypertension (High Blood Pressure) \square Mother \square Father \square Sibling \square Child \square Other: ☐ Kidney Disease _____ \square Mother \square Father \square Sibling \square Child ☐ Other: ☐ Mental Illness \square Father \square Sibling \square Child \square Other: \square Mother ☐ Osteoporosis \square Mother \square Father \square Sibling \square Child ☐ Other: _ ☐ Heart Attack < 50 yrs \square Mother \square Father \square Child \square Other: ☐ Sibling ☐ Seizures/Epilepsy \square Sibling \square Mother \square Father \square Child \square Other: ☐ Thyroid Problems \square Mother \square Father \square Sibling \square Child \square Other: ☐ Other: \square Mother \square Father \square Sibling \square Child ☐ Other: **SOCIAL HISTORY:** Check &/or answer each question. Tobacco Use: ☐ Current ☐ Former (Quit Year _____) ☐ Never ☐ Exposure to Smoke ☐ E-Cigs ☐ Other _ Alcohol Use: □ Never drink □ Occasional/social drinker □ # of drinks/day of alcohol Drug Use: ☐ None ☐ Other use Caffeine Use: \square No \square Yes – How much? Exercise: ☐ Sedentary ☐ Light ☐ Moderate **Marital Status:** ☐ Married ☐ Divorced ☐ Widowed ☐ Single Spouse's Name: ____ # of Children? _____ # of Grandchildren? ___ **Living Arrangements:** ☐ Independent - ☐ Alone or ☐ With Others ☐ Nursing Home ☐ Assisted Living Facility ☐ With Caregiver(s) **Employment:** Current Job/Occupation? **Sexually Active:** □ No □ Yes – with □ Male □ Female □ Both # of _____ sexual partners **WOMENS HEALTH HISTORY:** Check &/or answer each question. Age of first period: ____ yrs old Has menopause started/occurred? □ No □ Yes- at age ______yrs Number of days between periods: _____ Number of days period lasts: _____ Flow is: □ light □ moderate □ heavy Number of: Total pregnancies: ____ Full term births: ____ Premature births: ____ Number of : Vaginal Births: __ Miscarriages: ____ Abortions: ____ C-section: Pregnancy Complications: ☐ None ☐ Yes- ☐ High blood pressure ☐ Diabetes ☐ Pre-eclampsia ☐ other:_ Birth Control: ☐ None ☐ Birth control pill ☐ DepoProvera □ IUD ☐ Partner-Vasectomy ☐ Other

MEDICAL HISTORY - Page 3												
Name:			DOB	:/	/	/						
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ALLEDCIES. List all allergies and the type of regetion (Eyr Sulfa mak Codeing rouses at a)												
ALLERGIES: List all allergies and the type of reaction (Ex: Sulfa- rash, Codeine- nausea, etc.) Allergies Type of Reactions												
1.		Type of Reactions										
2.												
3.												
4.												
CURRENT MEDICATIONS: List all medications												
Medicine			ver the Counter mins/Supplements	Dosage	How often?		Provider					
Ex: Lasix				20mg	Twice a day		Dr. Jones					
1.												
2.												
3.					-							
4. 5.												
6.												
7.												
8.												
9.												
10.												
Immunizations: Plea	use check ($$) all that apply ***	*Pleas	se bring in a cop	y of your i	immuni	zation r	ecords**					
Adult Vaccines Administered Date			Adult Vaccines	1		Admin	istered Date					
☐ Tetanus												
☐ Pneumonia			☐ Shingles ☐ Other:									
☐ Flu Shot												
☐ Hep B												
1			☐ Other:			ı						
PREVENTATIVE C	CARE: Please list the dates o	f vour	last test and result	s if known								
Test	TITEL Trease his the dates of	Da		s ij into mi	Resu	lts						
Mammogram		Da			Itesu	163						
Pap smear												
Colonoscopy												
^ •	lominal Aortic Aneurysm)											
	• ,				•							
DEPRESSION SCRI	EENING:											
Over the past two weeks, I have had little interest or pleasure in doing things: \Box No \Box Yes												
Over the past two weeks I have felt down, depressed or hopeless: \square No \square Yes												
Over the past two wee	ks i have ten down, depies	scu UI	nopeless. 110	□ 1 C3								



MEDICAL HISTORY Page 4 Name: DOB: ____/ **REVIEW OF SYSTEMS:** Check all that you are *currently* experiencing. ☐ Feeling Tired or Poorly □ Red Blood in Bowel Movement □ Fever □ Diarrhea □ Chills □ Constipation □ Headache □ Blood in Urine ☐ Urinating frequently more than twice a night □ Sinus Pain ☐ Urinary Loss of Control □ Neck Symptoms □ Pain During Urination □ Vision Problems □ Earache □ Pain in Flank □ Nasal Symptoms □ Vaginal Discharge ☐ Musculoskeletal Symptoms □ Sore throat ☐ Chest pains or Discomfort □ Soft Tissue Swelling ☐ Localized soft tissue swelling in both legs □ Palpitations □ Difficulty Breathing □ Motor Disturbances □ Sensory Disturbances □ Cough □ Wheezing □ Anxiety □ Heartburn □ Depression □ Insomnia □ Nausea □ Skin Lesion □ Vomiting □ Abdominal pain □ Skin: a rash □ Black or Tarry Stools Additional information you would like to share with the provider: