

FAMILY MEDICAL GROUP
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Family Medical Group

Providing Quality Health Care in Turlock since 1952

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Medical History Form

Name: _____

Date: _____

Please list any current medical concerns:

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Past Hospitalizations:

Date	Reason for Hospitalization

Past Surgeries:

Date	Reason for Surgery

Medications (include aspirin, herbs, supplements, birth control pills):

Medication	Dosage

Allergies to Medications/Foods:

Medication/Food	Reaction

SOCIAL HISTORY

Name: _____

Where were you born? _____
 How far have you gone in school? _____
 Have you traveled outside of the U.S.? _____
 What kind of work do you do now? _____
 What kind of work have you done in the past? _____

Are you exposed to any chemicals or gases at work? _____
 Have you ever been disabled (complete or partial)? _____
 Have you ever been rejected for a job, the military, or life insurance? _____
 What are your hobbies? _____
 Are you married? _____ Name of spouse _____
 Is religion important _____ Religious preference _____

HABITS

Do you smoke? _____ Have you ever smoked? _____
 How many packs per day? _____ How many years? _____
 How much alcohol do you drink on the average? _____
 Have you ever felt the need to cut down on alcohol use? _____
 Has alcohol ever caused you problems (job, family, DUI's, etc.)? _____
 Do you drink coffee? _____ tea? _____ soft drinks? _____
 How many cups a day? _____
 Are you on a special diet? _____
 Do you exercise regularly? _____
 What do you do? _____ How often? _____
 Do you always wear seatbelts? _____ Have you ever used injectable drugs? _____

FAMILY HISTORY

	If Still Living		Age at Death	If No Longer Living
	Age	Health Conditions		Cause of Death
Father				
Mother				
Brothers and Sisters				
Children				

Have any of your blood relatives had any of the following illnesses? (Indicate with a ✓)

	Relationship		Relationship
_____ High Blood Pressure	_____	_____ Tuberculosis	_____
_____ Heart Attack	_____	_____ Asthma	_____
_____ Other Heart Disease	_____	_____ Other Lung Disease	_____
_____ Stroke	_____	_____ Diabetes	_____
_____ Seizures/Epilepsy	_____	_____ Cancer (stomach, breast, colon, etc.)	_____
_____ Nerve Problems	_____	_____ Colon polyps	_____
_____ Migraine Headaches	_____	_____ Mental Disorder	_____
_____ Kidney Disease	_____	_____ Depression	_____
_____ Anemia	_____		
_____ Bleeding Disorder	_____		

Name _____

Have you, in the last 12 months, had any of the following?
Please circle yes or no.

<u>GENERAL</u>		<u>HEART / VASCULAR</u>	
Fatigue (tire easily)	yes no	Chest pain / discomfort	yes no
Fever or chills	yes no	Sudden rapid heart rate	yes no
Night sweats	yes no	Irregular heart rhythm	yes no
Weight change	yes no	Short of breath at night	yes no
Hay Fever / Allergies	yes no	Ankle swelling	yes no
		Heart murmur	yes no
		Heart attack	yes no
		High blood pressure	yes no
		Leg pain while walking	yes no
		Varicose veins	yes no
<u>EYES</u>		<u>HEMATOLOGY</u>	
Use glasses/contacts	yes no	Anemia	yes no
Double or blurry vision	yes no	Bleeding tendency	yes no
Other difficulty seeing	yes no	Leukemia	yes no
Eye pain or redness	yes no	Blood transfusion	yes no
Watery eyes	yes no	If yes, what year? _____	
Glaucoma	yes no		
		<u>GI</u>	
		Loss or change in appetite	yes no
		Difficulty swallowing	yes no
		Heartburn / indigestion	yes no
		Abdominal pain	yes no
		Nausea / vomiting	yes no
		Diarrhea	yes no
		Constipation	yes no
		Hemorrhoids	yes no
		Rectal bleeding	yes no
		Black stools	yes no
		Vomited blood	yes no
		Jaundice / Hepatitis	yes no
		Intestinal polyps	yes no
		Ulcers	yes no
		Gallstones / Gall bladder problems	yes no
		Change in bowel habits	yes no
		<u>GU</u>	
		Painful urination	yes no
		Frequent urination	yes no
		Slowing of urine stream	yes no
		Up at night to urinate	yes no
		Blood in urine	yes no
		Urine infections	yes no
		Loss of control of urine	yes no
		Prostate problems	yes no
		Loss of sex drive	yes no
		Painful intercourse	yes no
		Other sexual difficulty	yes no
		Use contraception	yes no
		Kidney problems	yes no
<u>EARS</u>			
Loss of hearing	yes no		
Ear infections	yes no		
Ringing in ears	yes no		
Hearing Aid	yes no		
<u>NOSE</u>			
Loss of smell	yes no		
Nose bleeds	yes no		
Chronic runny nose	yes no		
Sinus problems	yes no		
<u>MOUTH</u>			
Use dentures	yes no		
Tooth problems	yes no		
Sore throat	yes no		
Change in voice	yes no		
<u>BREASTS</u>			
Lump in breast	yes no		
Discharge or bleeding	yes no		
Pain	yes no		
Breast cancer	yes no		
<u>LUNGS</u>			
Recent cough	yes no		
Chronic cough	yes no		
Coughed up blood	yes no		
Wheezing	yes no		
Shortness of breath	yes no		
Pain with breathing	yes no		
Pneumonia / bronchitis	yes no		
Asthma	yes no		
Emphysema	yes no		
Cough up sputum / mucous	yes no		

SKIN

Rash	yes	no
Moles (new or changing)	yes	no
Hives	yes	no
Eczema	yes	no
Change in hair or nails	yes	no
Tumors / cysts	yes	no
Cancer	yes	no

MUSCULOSKELETAL

Joint pain or swelling	yes	no
Broken bones	yes	no
Head / back injury	yes	no
Neck or back pain	yes	no
Disability from back or other injury	yes	no
Painful muscles	yes	no
Arthritis	yes	no

ENDOCRINE

Always warm	yes	no
Always cold	yes	no
Thyroid problems	yes	no
Excessive thirst	yes	no
Diabetes	yes	no

NEUROLOGIC

Headache	yes	no
If yes, how often? _____		
Dizziness	yes	no
Seizures / epilepsy	yes	no
Blackouts / fainting	yes	no
Numbness / tingling	yes	no
Weakness / paralysis	yes	no
Coordination difficulty	yes	no
Stroke	yes	no
Lose balance easily	yes	no
Pain in arms / legs	yes	no
Nervousness	yes	no
Difficulty concentrating	yes	no
Memory loss	yes	no
Difficulty sleeping	yes	no
Increased moodiness	yes	no
Thoughts of suicide	yes	no
Previous depression	yes	no

Name _____

INFECTIOUS

Measles	yes	no
Mumps	yes	no
Polio	yes	no
Scarlet fever	yes	no
Rheumatic fever	yes	no
Meningitis	yes	no
Tuberculosis	yes	no
Exposure to tuberculosis	yes	no
AIDS	yes	no
Hepatitis	yes	no
Venereal Disease	yes	no

IMMUNIZATIONS

Have you had shots for:			Date of last st
tetanus	yes	no	_____
measles	yes	no	_____
mumps	yes	no	_____
rubella	yes	no	_____
pneumonia (Pneumovax)	yes	no	_____
hepatitis	yes	no	_____

FOR WOMEN

Painful periods	yes	no
Vaginal itching / discharge	yes	no
Irregular bleeding	yes	no
Menopause	yes	no
If yes, when _____		
Bleeding after menopause	yes	no
Hot flashes	yes	no
Vaginal dryness	yes	no
Regularly do breast exam	yes	no

Are you pregnant at the present time?

If yes, delivery date _____

Age when periods started _____

Date of last period _____

Number of pregnancies _____

Number of deliveries _____