Family Medical Group

911 East Tuolumne Road, Turlock, CA 95382
209.668.4101 Fax 209.668.3758 www.fmgturlock.com

Medical History Form

Name ______________________________ Date ______________ DOB ______________

Please list any current medical concerns.

____

____

____

____

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 / Food

Medication / Food	Reaction

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Name ______________________________ DOB __________

SOCIAL HISTORY

Where were you born? ______________________________

How far have you gone in school? ______________________________

Have you traveled outside ot the U.S.? ______________________________

What kind ot work do you do now? ______________________________

Whal 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 rnany 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		If No Longer Living	
	Age	Health Conditions	Age at Death	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 Pronlems	________	________	Colon polyps	________
________	Migraine Headaches	________	________	Mental Disorder	________
________	Kidney Disease	________	________	Depression	________
________	Anemia	________			

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

GENERAL		
Fatigue (tire easily)	yes	no
Fever or chills	yes	no
Night sweats	yes	no
Weight change	yes	no
Hay Fever / Allergies	yes	no

EYES		
Use glasses / contacts	yes	no
Double or blurry vision	yes	no
Other difficulty seeing	yes	no
Eye pain or redness	yes	no
Watery eyes	yes	no
Glaucoma	yes	no

EARS		
Loss of hearing	yes	no
Ear infections	yes	no
Ringing in ears	yes	no
Hearing aid	yes	no

NOSE		
Loss of smell	yes	no
Nose bleeds	yes	no
Chronic runny nose	yes	no
Sinus problems	yes	no

MOUTH		
Use dentures	yes	no
Tooth problems	yes	no
Sore throat	yes	no
Change in voice	yes	no

BREASTS		
Lump in breast	yes	no
Discharge or bleeding	yes	no
Pain	yes	no
Breast Cancer	yes	no

LUNGS		
Recent cough	yes	no
Chronic cough	yes	no
Cough 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

HEART / VASCULAR		
Chest pain / discomfort	yes	no
Sudden rapid heart rate	yes	no
Irregular heart rhythm	yes	no
Short of breath at night	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

HEMATOLOGY		
Anemia	yes	no
Bleeding tendency	yes	no
Leukemia	yes	no
Blood transfusion	yes	no

If yes, what year? ______________

GI		
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

GU		
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 sexaul difficulty	yes	no
Use contraception	yes	no
Kidney problems	yes	no

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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 trom 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
	yes	no

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 shot
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 ______________