Family Medical Group

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Medical History Form

Name:_____ Date:_____

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/Foods:

Medication/Food	Reaction

Medical History Form

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 even 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			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
_____	High Blood Pressure	_____
_____	Heart Attack	_____
_____	Other Heart Disease	_____
_____	Stroke	_____
_____	Seizures/Epilepsy	_____
_____	Nerve Problems	_____
_____	Migraine Headaches	_____
_____	Kidney Disease	_____
_____	Anemia	_____

		Relationship
_____	Tuberculosis	_____
_____	Asthma	_____
_____	Other Lung Disease	_____
_____	Diabetes	_____
_____	Cancer (stomach, breast, colon, etc.)	_____
_____	Colon polyps	_____
_____	Mental Disorder	_____
_____	Depression	_____

Medical History Form

Name _____

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
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

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 sexual difficulty	yes	no
Use contraception	yes	no
Kidney problems	yes	no

Medical History Form

Name _____

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

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 _____