Family Medical Group

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/Foods:

Medication/Food	Reaction

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Medical History Form

Name: _____ **DOB:** _____

SOCIAL HISTORY

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, DUIs, 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 an X)

		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	_____			

Medical History Form

Name: _____ DOB: _____

Have you, in the last 12 months, had any of the following? Please check 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 difficult 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

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Have you, in the last 12 months, had any of the following? Please check yes or 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

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?	☐ yes	☐ no
If yes, delivery date	_____	
Age when periods started	_____	
Date of last period	_____	
Number of pregnancies	_____	
Number of deliveries	_____	