First Name: ________________________ Last Name: ___________________________________ DOB: ____________________

ID# ___________________________________ MRN#________________________

Medical History Form

Personal Information		
Address:	Phone (Home):	Insurance:
City, State, Zip:	Phone (Cell): _______________________ Can we text you? Yes No	Sex at BIrth: Male Female Ethnicity: __________________________ Sexual Orientation: ___________________
Occupation:	Email:	Do you have an Advanced Directive? Yes No If yes, please bring it to your visit. If no, please fill the appropriate form.

Marital Status: Single Married Separated Divorced Widow	Preferred Language: English Español Tiếng Việt عربي

Family Health History: If your blood relatives have suffered any of the following, check the box and indicate which relative.		
☐ Heart Disease ______________	☐ Stroke ____________________	☐ Alcoholism _________________
☐ Hypertension _______________	☐ Epilepsy __________________	☐ Osteoporosis ________________
☐ Kidney Disease _____________	☐ Cancer ____________________	☐ Arthritis ___________________
☐ Lung Disease _______________	☐ Glaucoma _________________	☐ Hay fever __________________
☐ Asthma ____________________	☐ Migraines __________________	☐ Mental Illness _______________
☐ Diabetes ___________________	☐ Anemia ____________________	☐ Other:
☐ Thyroid Disease _____________	☐ Bleeds Easily _______________	______________________________ ______________________________

Hospital Stays (Name of Hospital)	*Year*	*Reason*	*Allergies*
1) ________________________	__________	________________________	Past:
2) ________________________	__________	________________________	
3) ________________________	__________	________________________	Present:
4) ________________________	__________	________________________	
5) ________________________	__________	________________________	

First Name: ______________________ Last Name: ________________________________ DOB: __________________

ID# ________________________________ MRN#______________________

Surgical History	*Year*		*Year*
☐ Appendectomy	____________	☐ Other Surgeries:	
☐ Cholecystectomy	____________	1) ______________________	____________
☐ Cesarean Section	____________	2)______________________	____________
☐ Breast surgery	____________	3)______________________	____________
☐ Cardiac stent placement/surgery	____________	4)______________________	____________

Medical History: Check the box beside any diseases you have.

Gastrointestinal Disease

- ☐ Indigestion / heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody or tarry stools
- ☐ Abdominal pain - chronic
- ☐ Weight loss - recent
- ☐ Gall bladder trouble
- ☐ Jaundice / hepatitis
- ☐ Crohn's / Colitis
- ☐ Peptic ulcers
- ☐ Diverticulosis
- ☐ Hernia
- ☐ Hemorrhoids

Urinary Disease

- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Urinary incontinence

Cardiovascular Disease

- ☐ Irregular pulse:
  - ☐ Palpitations
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Varicose veins / phlebitis
- ☐ High cholesterol

Lung Disease

- ☐ Asthma / Wheezing
- ☐ Pneumonia / pleurisy
- ☐ Chronic bronchitis / COPD
- ☐ Tuberculosis
- ☐ Other: ______________

Musculoskeletal Disease

- ☐ Arthritis
- ☐ Chronic back pain
- ☐ Osteoporosis
- ☐ Bone fracture: ______________
- ☐ Muscle weakness
- ☐ Gout

Psychiatric Disease

- ☐ Phobias
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Mental illness
- ☐ Depression

Neurological Disease

- ☐ Headaches - frequent
- ☐ Memory loss
- ☐ Dizzy spells
- ☐ Double or blurred vision
- ☐ Failing vision
- ☐ Nervousness
- ☐ Stroke
- ☐ Numbness / tingling
- ☐ Convulsions / Seizures
- ☐ Fainting spells
- ☐ Polio

Ear/Nose/Throat Disease

- ☐ Ringing in ear
- ☐ Decreased hearing
- ☐ Chronic Sinusitis
- ☐ Difficulty swallowing

Immunologic Disease

- ☐ Hay fever / allergies
- ☐ Psoriasis

Endocrine Disease

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other ______________

Hematologic Disease

- ☐ Anemia:
  - ☐ Bruise easily
- ☐ Blood disease
- ☐ Other: ______________

Cancers

- ☐ Please specify:

First Name: ________________________ Last Name: ___________________________________ DOB: ____________________

ID# ___________________________________ MRN#________________________

☐ Enlarged prostate (males)			________________

Medications: List all prescriptions, vitamins, herbal supplements and over-the-counter drugs you are currently taking, with dosage.

1) ______________________________ _______ per day 6) ___________________________________ _______ per day
2) ______________________________ _______ per day 7) ___________________________________ _______ per day
3) ______________________________ _______ per day 8) ___________________________________ _______ per day
4) ______________________________ _______ per day 9) ___________________________________ _______ per day
5) ______________________________ _______ per day 10) __________________________________ _______ per day

Main Problems / Health Conditions	*Comments*
1.	
2.	
3.	
4.	
5.	

Vaccines	*Date of last vaccine*	*Tests / Exams*	*Date of last test / exam*
Tetanus / Diphtheria	____________________	Cholesterol	____________________
Influenza	____________________	Dental	____________________
Pneumococcal ➔ Recommended for ages 65+	____________________	Eye	____________________
Hepatitis	____________________	Hearing	____________________
HPV ➔ Ages 9-45	____________________	Rectal / Stool	____________________
Shingles ➔ Recommended for ages 50+	____________________	Sigmoidoscopy	____________________
		Tuberculosis / TB skin test	____________________

Personal Habits / Lifestyle Choices

☐ Smoking: Cigarettes / packs per day: ________ Started smoking when? ____________ Are you interested in quitting? Yes No

☐ Diet: Needs counseling: Yes No

☐ Coffee: Cups per day: ______________ Other sources of caffeine: ____

First Name: __________________ Last Name: __________________________ DOB: _______________

ID# __________________________ MRN#__________________

☐ Alcohol: Type: ________________________ Amount per day: _____________________________

☐ Sleep: Difficulty falling asleep Early morning awakening Staying asleep Daytime drowsiness

☐ Exercise Routine: Amount of time: _____________________ Days per week: ______________________

Men Only	
Sexually active? Yes No	Prostate exam: ______________________________
It is common for men to occasionally experience erection problems.	Normal Abnormal
Does this happen to you? Yes No	PSA Test: ________________________________
How often does this occur? Frequently Sometimes Rarely	Colonoscopy: ______________________________

Women Only	
Sexually active? Yes No Pain / Bleed during / after sex	☐ Flushing / menopause
Currently pregnant? Yes No Pregnancies: ____ Live births: ____	Last pelvic exam: ____________ Last PAP test: ____________
Planning pregnancy? Yes No Abortions: ____ Miscarriages: ____	Last breast exam: ____________ Normal Abnormal
Menses:: Regular Irregular	Last mammogram: ____________ Normal Abnormal
Explain: ________________________________	
Last menstrual period: __________________________	Colonoscopy: ______________________________

____

Physician's Printed Name *Physician's Signature* *Date*