Name: _____ Date of Birth: _____

MEDICAL HISTORY FORM

Sex assigned at birth: Female / Male

PAST MEDICAL HISTORY/PROBLEM LIST: *EXAMPLE diabetes, headaches, or stroke*
Please select and list ALL known medical conditions (past and present).

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Thyroid Issues ☐ Stroke

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGY HISTORY: *EXAMPLE: penicillin* reaction: *hives or rash*
Please list ALL known medication, food, and environmental allergies.

1_____ reaction: _____
2_____ reaction: _____
3_____ reaction: _____
4_____ reaction: _____
5_____ reaction: _____

MEDICATIONS/PRESCRIPTIONS: *EXAMPLE: Atenolol* dose: *50mg* how often: *twice daily*
Please list ALL prescriptions, supplements, and over-the-counter medications you are currently taking.

1_____ dose: _____ how often: _____
2_____ dose: _____ how often: _____
3_____ dose: _____ how often: _____
4_____ dose: _____ how often: _____
5_____ dose: _____ how often: _____
6_____ dose: _____ how often: _____
7_____ dose: _____ how often: _____
8_____ dose: _____ how often: _____
9_____ dose: _____ how often: _____
10_____ dose: _____ how often: _____

Preferred Pharmacy and Location: _____

PREVENTATIVE SCREENING:

Last physical exam: _____ Last lab testing/blood-work: _____
Last colonoscopy / colon cancer screen: _____ Results:_____
Last PSA / prostate cancer screen: _____ Results: _____
Last LDCT/lung cancer screening: _____ Results: _____
Last TB test: _____ ☐ Normal ☐ Abnormal
Have you EVER been exposed to tuberculosis? ☐ Yes ☐ No
Have you ever been tested for Hepatitis C? _____ ☐ POS ☐ NEG
Have you ever been tested for HIV? _____ ☐ POS ☐ NEG
Last PAP smear:_____ ☐ Normal ☐ Abnormal
Have you EVER had an abnormal PAP? _____
Last mammogram: _____ ☐ Normal ☐ Abnormal
Have you EVER had an abnormal mammogram? _____

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Name: _____ Date of Birth: _____

Last bone density/DEXA: _____ Results: _____
Last eye exam: _____ Specialist: _____
Last skin exam:_____ Specialist: _____

Please list the names of ALL other physicians or specialists that you see:
EXAMPLE: Dr Joe Smith (cardiologist), Dr Jane Doe (gastroenterologist), etc

_____
_____
_____

GYNECOLOGICAL HISTORY:
Date of last menstrual period:_____ Are you in menopause? ☐ YES ☐ NO
Age of menarche / first period: _____
Total number of pregnancies: _____
How many were full term deliveries? _____ pre-term deliveries? _____
How many were miscarried or terminated? _____

SURGICAL HISTORY: *Please list all surgeries you have had including the reason for surgery*
EXAMPLE: hysterectomy Date: *9/1986* Reason: *fibroids/heavy bleeding*
1_____ date: _____ reason:_____
2_____ date: _____ reason:_____
3_____ date: _____ reason:_____
4_____ date: _____ reason:_____
5_____ date: _____ reason:_____

HOSPITALIZATIONS: *Please list all reasons you were in the hospital within the last 5 years.*
EXAMPLE: blood clot Date: 8/1990
1_____ date: _____
2_____ date: _____
3_____ date: _____
4_____ date: _____
5_____ date: _____

PROCEDURE HISTORY: *Please list all other procedures you have had and why you had them*
EXAMPLE: cardiac stress test Date: *7/1996* Reason: *chest pain with exercise*
1_____ date: _____ reason:_____
2_____ date: _____ reason:_____
3_____ date: _____ reason:_____
4_____ date: _____ reason:_____

FAMILY HISTORY:
Father: ☐ living ☐ deceased at age _____ ☐ unknown
Medical conditions: _____
Mother: ☐ living ☐ deceased at age _____ ☐ unknown
Medical conditions: _____
How many brothers do you have? _____
Medical conditions: _____
How many sisters do you have? _____
Medical conditions: _____
How many sons do you have? _____Medical conditions:_____

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Name: _____ Date of Birth: _____

How many daughters do you have? _____Medical conditions:_____
Is there any family history of:
☐ breast cancer ☐ colon cancer ☐ lung cancer ☐ other cancer: _____

SOCIAL HISTORY:
Marital Status: _____ Sexual Orientation:_____
Religious Preference: _____ Pronouns:_____
Occupation : _____ Exercise Routine:_____
Hobbies : _____

TOBACCO USE:
☐ Never smoked
☐ Past smoker: ☐ Cigarettes ☐ Cigars ☐ E-cigarettes ☐ Vape
How many packs-per-day did you smoke? _____
When did you start smoking? _____When did you quit? _____
☐ Current smoker: ☐ Cigarettes ☐ Cigars ☐ E-cigarettes ☐ Vape
How many packs-per-day do you smoke? _____
When did you start smoking? _____
☐ I use other forms of tobacco: _____

ALCOHOL USE:
How often do you have a drink containing alcohol? _____
How many drinks containing alcohol do you have on a typical day when you are drinking? _____
How often did you have six or more drinks on 1 occasion within the past year? _____
What type of alcohol do you usually drink? ☐ Liquor ☐ Beer ☐ Red Wine ☐ White wine ☐ _____

CAFFEINE USE:
☐ Coffee – how many servings per day? _____ Decaf? _____
☐ Tea – how many servings per day? _____
☐ Soda / Pop – how many servings per day? _____
☐ Energy Drinks / Other _____ How many servings per day?_____

OTHER DRUG USE:
Do you CURRENTLY use any recreational drugs? ☐ Yes ☐ No Explain: _____
Have you EVER used any recreational drugs? (in the past) ☐ Yes ☐ No Explain: _____
Have you ever used or shared needles? ☐ Yes ☐ No

DO YOU HAVE ANY ADVANCED DIRECTIVES, IN PLACE? *If yes, please provide a copy to us*
☐ Living Will ☐ Medical Power of Attorney ☐ Other:_____
☐ POLST ☐ Do Not Resuscitate Orders (DNR)

IMMUNIZATIONS: *(list most recent dates if known)*:
Influenza: _____ Tetanus (Td or Tdap): _____
Pneumonia: _____ Shingles (Zostavax or Shingrix): _____
Hepatitis B: _____ Other: _____

Staff Reviewed:
Date:

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Name: _____ Date of Birth: _____

For **New Patient Visits**, my main concerns that I want to be sure that I address *and* discuss with my medical provider are:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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