Patient Name: _____ DOB:_____ Today's Date: _____

Preferred Pronoun: She / Her He / His They / Their

Medical History Form

Review of Systems

Are you currently experiencing any of the following symptoms?

General:
- ☐ Excessive Weight Gain | Loss
- ☐ Fatigue
- ☐ Fever | Chills
- ☐ Night Sweats
- ☐ Weakness

Skin:
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives | Rash
- ☐ Jaundice | Yellowing

HEENT:
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Visual Changes
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Postnasal Drainage
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat

Respiratory:
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Difficulty Breathing on Exertion
- ☐ Palpitations
- ☐ Swelling of Extremities

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Groin Pain
- ☐ Incontinence
- ☐ Pelvic Pain
- ☐ Urgency

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Stiffness

Neurologic:
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tingling
- ☐ Tremor
- ☐ Passing Out

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble Focusing

Endocrine:
- ☐ Excessive Thirst
- ☐ Cold or Heat Intolerance

Hematology:
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Nodes

Patient Name: _____ DOB:_____ Today's Date: _____

Past Medical History

Heart
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Atrial Fibrillation

Lungs
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea

Dermatology
- ☐ Skin Cancer
- ☐ Acne

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar

Stomach
- ☐ Heartburn
- ☐ Ulcers
- ☐ Irregular Bowel
- ☐ Diverticulitis
- ☐ Liver Disease

Musculoskeletal
- ☐ Arthritis
- ☐ Gout

Urology
- ☐ Kidney Stones
- ☐ Prostate Issues

Other
- ☐ Anemia
- ☐ Blood Clots
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ _____
- ☐ _____

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Gestational Diabetes
- ☐ Thyroid

Neurologic
- ☐ Stroke
- ☐ Headache
- ☐ Migraine
- ☐ Dementia

Gynecology
- ☐ Endometriosis
- ☐ HPV
- ☐ Abnormal Pap
  When _____

Cancer: List What Type
- ☐ _____
- ☐ _____
- ☐ _____

Social History

Tobacco Use: ☐ Never
☐ Current: Cigarettes ☐ Yes ☐ No Amt: _____ pck/day Has been smoking for? _____
Smokeless Tobacco ☐ Yes ☐ No Amt: _____ per day
Cigars ☐ Yes ☐ No Amt: _____ # week ☐ E-Cigarettes
☐ Quit: Year last smoked _____ Amt: _____ pck/day How many years did you smoke? _____
Children: Secondhand smoke exposure? ☐ Yes ☐ No
Alcohol Use: ☐ Yes ☐ No _____ # drinks per day | week | occasional | social
Caffeine Use: ☐ Yes ☐ No _____ # drinks per day | week | occasional | social
Seatbelt Use: ☐ Yes ☐ No
Exercise: ☐ Yes ☐ No Times per week: _____ Type of exercise: _____
Occupation: _____
Have you ever used **street drugs**: ☐ Yes ☐ No Which ones: ☐ Marijuana ☐ IV drugs ☐ Cocaine
☐ Amphetamines ☐ Heroin ☐ Inhalants ☐ Other _____
Are you still using? ☐ Yes ☐ No Which ones: _____
Do you have a medical marijuana card? ☐ Yes ☐ No
Are you sexually active (in the last year)? ☐ Yes ☐ No ☐ Never
If yes check all that apply: ☐ 1 Partner ☐ Multiple Partner(s) ☐ 5 or more Partners in your Lifetime
☐ Male Partner(s) ☐ Female Partner(s) ☐ Both
Is there concern for your safety? ☐ Yes ☐ No ☐ Emotional ☐ Physical ☐ Sexual Abuse
Education Level: ☐ Did Not Complete HS ☐ Completed HS ☐ College Graduate ☐ Graduate Education
Any cultural or religious concerns related to your healthcare? ☐ Yes ☐ No

Patient Name: _____ DOB:_____ Today's Date: _____

Family History

Have any of your family members had any of the following problems?

☐ Alcoholism	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Asthma	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Breast Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Colon Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Depression	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Heart Attack	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Lung Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Migraines	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Osteoporosis	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Ovarian Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Skin Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Thyroid Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Uterine Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Other Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Other Diagnosis	☐ Father	☐ Mother	☐ Sibling	☐ Other _____
☐ Other Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Other _____

List all **ALLERGIES** to any medications **and** the reactions: ☐ No Known Drug Allergies

☐ Latex ☐ Iodine ☐ Eggs

Medication	Reaction

IMMUNIZATIONS: (List Dates)

Hepatitis A: _____

Hepatitis B: _____

Td - Adult Tetanus Toxoid: _____

Influenza: _____

Pneumonia: _____

PPD - Tuberculin Skin Test: ☐ Negative ☐ Positive

_____

Shingles: _____

COVID: _____

Gardasil (HPV): _____

Patient Name: _____ DOB:_____ Today's Date: _____

CURRENT MEDICATIONS: *(Please include over the counter medication and food supplements.)*

Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____
Drug Name:_____ Dose: _____ How Often: _____

☐ None

Pregnancy and Birth

Date of Last Menstrual Period: _____ Age of First Period: _____

Are you Menopausal? ☐ Yes ☐ No Age at Onset of Menopause: _____

# of Pregnancies: _____ # of Live Births: _____ # of Abortions: _____ # of Miscarriages _____

# of Living Children: _____

Past Surgical History

List all SURGERIES and DATES you have had:

Type of Surgery	Date
☐ Appendectomy	
☐ Arthroscopy (Joint)	
☐ Back Surgery or ☐ Neck Surgery	
☐ Cataract Surgery	
☐ Cesarean Section	
☐ Gallbladder Removal	
☐ Heart Surgery (Specify)	
☐ Hemorrhoids	
☐ Hernia (Specify)	
☐ Hysterectomy	
☐ Knee Replacement or ☐ Hip Replacement	
☐ Mastectomy or Lumpectomy (Specify)	
☐ Polyp Removal (Colon)	
☐ Tonsillectomy or ☐ Adenoidectomy	
☐ Tubal Ligation or ☐ Vasectomy	
☐ Plastic Surgery (Specify)	
☐ Other (Specify)	
☐ Other (Specify)	

Patient Name: _____ DOB:_____ Today's Date: _____

Health Maintenance

List Where if Known

Date of last Pap Smear:_____ (mo/yr) Where: _____

Date of last PSA level: _____ (mo/yr) Where: _____
(Prostate Cancer Screening)

Date of last Mammogram: _____ (mo/yr) Where: _____

Date of last Bone Density: _____ (mo/yr) Where: _____

Date of last Colonoscopy:_____ (mo/yr) Where: _____

Lung Cancer Screening: _____ (mo/yr) Where: _____

DIABETIC PATIENTS

Date of last Eye Exam: _____ (mo/yr) Where: _____

Please provide **first & last** names of all other physicians that you currently see and their specialty:

_____

_____

What is your preferred pharmacy (Please include name and phone number and/or location):

_____

_____

What is your preferred mail order pharmacy (Please include name and phone number):

_____

_____