Your Family

Doktors

Name_____ Date of birth_____

Last ,First, middle initial month/day/year

A medical history form is one of the most important pieces of information you can give to your doctor. Please fill in this information to the best of your ability.

Medical History

Family History

	Age	Alive	Died	Medical problems of this family member (please list)
Mother				
Father				
Mat. GM				
Mat. GF				
Pat GM				
Pat GF				
Sister(s)				
Brother(s)				

Social history

Did you smoke, chew tobacco, or vape? Y N How much per day? For how many years?

Are you still smoking, chewing, or vaping? Y N If not, when did you quit?

Do you drink alcohol? Y N How often? How many drinks at a time?

Have you ever abused alcohol? Y N When? Details?

Have you used illegal drugs? Y N When? What type?

Have you ever abused prescription drugs? Y N Details?

Do you consume caffeine? Y N What form? How many a day?

Do you wear seatbelts regularly? Y N Do you wear a bike helmet? Y N NA

Have you been physically abused? Y N Verbally abused? Y N

Do you have a smoke alarm? Y N Does it have a carbon monoxide monitor? Y N NA

Do you exercise regularly? Y N What type? How often?

Have you lost/gained weight this year? Y N If so how much?

Are you: single married separated divorced widowed? (circle) Number of children?

What kind of work do you do?

Please list all of the surgeries and hospitalizations you have had.

Year Reason for hospitalization/Type of surgery

List all medication allergies:

_____

List all current medications (list name, dosage, and frequency. Please include vitamins and herbal supplements): _____

_____

_____

_____

_____

_____

Please check Y or N for each of the diseases listed. If yes, please indicate what year the disease was diagnosed.

Cardiac	**Y**	**N**	**Year**	
High blood pressure	____	____	_____	
High cholesterol	____	____	_____	Total chol_____LDL____HDL____Trig____
Chest pain/ Angina	____	____	_____	
Heart Attack	____	____	_____	
Stroke	____	____	_____	
Mini-Stroke/TIA	____	____	_____	
Shortness of breath	____	____	_____	
Heart murmur	____	____	_____	Type if know: Aortic/Mitral/Tricuspid/Pulmonic
Congestive heart failure	____	____	_____	
Heart blockage	____	____	_____	
Blockage in the legs	____	____	_____	
Ankle swelling	____	____	_____	
Varicose veins	____	____	_____	
Irregular heartbeat/palpitations /arrhythmia	____	____	_____	Type, if known: Atrial fibrillation/SVT/PVC's
Other:				_____
Last EKG/electrocardiogram?			_____	Was it normal? Y N

Pulmonary	**Y**	**N**	**Year**	
Asthma	____	____	_____	
Emphysema/COPD	____	____	_____	
Bronchitis	____	____	_____	
Pneumonia	____	____	_____	
Shortness of breath	____	____	_____	
Snoring	____	____	_____	
Sleep apnea	____	____	_____	Do you use a CPAP/APAP? (circle)
Covid19	____	____	_____	
Lung Cancer	____	____	_____	
Other:				_____
When was you last chest xray?			_____	Was it normal? Y N

Gastrointestinal	**Y**	**N**	**Year**	
Heartburn/GERD	____	____	_____	
Ulcer	____	____	_____	What type?_____
Gastritis	____	____	_____	
Gallstones	____	____	_____	Did you have surgery? Y N
Crohn's Disease	____	____	_____	
Ulcerative Colitis	____	____	_____	
Irritable Bowel syndrome	____	____	_____	
Diarrhea	____	____	_____	
Blood in stool/ black stools	____	____	_____	
Colon Polyps	____	____	_____	
Chronic diarrhea	____	____	_____	
Constipation	____	____	_____	
Hemorrhoids	____	____	_____	
Hepatitis/Jaundice	____	____	_____	What type?_____
Frequent abdominal pain	____	____	_____	
Colon Cancer	____	____	_____	
Other:				

Endocrine	**Y**	**N**	**Year**	
Diabetes	____	____	_____	Insulin dependent? Y N
Thyroid disease	____	____	_____	
Adrenal gland problem	____	____	_____	
Hypoglycemia	____	____	_____	
Low testosterone	____	____	_____	
PCOS	____	____	_____	
Other:				

Genitourinary	**Y**	**N**	**Year**	
Frequent bladder/kidney infections	____	____	_____	
Blood or protein in urine	____	____	_____	
Kidney stones	____	____	_____	
Intertestional cystitis	____	____	_____	
Incontinence	____	____	_____	
STDS	____	____	_____	Herpes Gonorrhea Chlamydia HIV HPV Tichomonas
Are you sexually active?	____	____		If yes, how many partners currently?_____
How many sex partners have you had? (total)			_____	Do you use condoms? Y N
Have you used IV drugs?	____	____	_____	Do you have tattoos? Y N
Have you ever received a blood transfusion?	_____			
(men) Impotence	_____			Do you preform monthly testicular exams? Y N
(men) Enlarged prostate	_____			
(men) Prostate cancer	_____			What was your last PSA?_____
Kidney or bladder cancer	____	____	_____	
Other:	_____			

Neurologic	**Y**	**N**	**Year**	
Frequent headaches	____	____	_____	Type: Migraine Sinus Tension/stress
Carpal tunnel syndrome	____	____	_____	Circle all that apply
TMJ	____	____	_____	
Seizures	____	____	_____	
Loss of consciousness	____	____	_____	
Numbness/tingling	____	____	_____	
Weakness	____	____	_____	Where?_____
Dizziness/Vertigo	____	____	_____	Where?_____
Other:				_____

Musculoskeletal	**Y**	**N**	**Year**	
Neck pain	____	____	_____	
Back pain	____	____	_____	
Broken bones	____	____	_____	Which ones?_____
Arthritis-Rheumatoid/Osteo (circle)	____	____	_____	Which joints?_____
Lupus	____	____	_____	
Gout	____	____	_____	
Osteoporosis/ Osteropenia (circle)	____	____	_____	Have you lost and height? Y N
Scoliosis	____	____	_____	
Other:				_____

Psychiatric	**Y**	**N**	**Year**	
Depression	____	____	_____	Hospitalized? Y N Ever suicidal? Y N
Bipolar (manic-depressive) disorder	____	____	_____	
Anxiety/Panic attacks	____	____	_____	
Phobias	____	____	_____	
Schizophrenia	____	____	_____	
Bulimia or Anorexia	____	____	_____	
Insomnia	____	____	_____	
Other:				_____

Hematologic	**Y**	**N**	**Year**
Anemia	____	____	_____
Low/High platelets	____	____	_____
High RBC/HCT	____	____	_____
High/Low WBC	____	____	_____
Other:			_____

Eyes	**Y**	**N**	**Year**	
Glaucoma	____	____	_____	**Do you wear corrective lenses? (circle below)**
Nearsighted	____	____	_____	Glasses
Farsighted	____	____	_____	Hard contacts
Cataracts	____	____	_____	Soft contacts
Blindness/Loss of vision	____	____	_____	Reading glasses
Astigmatism	____	____	_____	Have you has RK/Lasik? (circle)
Other:				_____

Ears, Nose, and Throat	**Y**	**N**	**Year**	
Hearing loss	____	____	_____	
Tinnitus/ Ringing of the ears	____	____	_____	
Vertigo	____	____	_____	
Frequent ear infections	____	____	_____	
Deviated septum	____	____	_____	
Chronic sore throat	____	____	_____	
Chronic sinusitis	____	____	_____	
Allergies	____	____	_____	What are you allergic to?_____

Other: _____

Skin	**Y**	**N**	**Year**	
Eczema/Seborrhea	____	____	_____	
Acne	____	____	_____	
Psoriasis	____	____	_____	
Chronic rashes/itching	____	____	_____	
Skin Cancer	____	____	_____	Type?(circle) Basal cell squamous cell melanoma

Other: _____

Immunization History

Type	**Year**	**Type**	**Year**
Flu	_____	Covid 19	_____ How many? _____
Pneumonia	_____	Tetanus	_____
Hepatitis B	_____	TB test	_____
Shingles	_____		

Circle all childhood diseases you have had: Chicken pox Measles Mumps Rubella

List and other medical problems you have been treated for that are addressed above:_____

_____

Female Gynecologic/ Obstetric History?

Are your periods regular? Y N When was your last one?_____

When was your last Pap smear? _____

Have you ever had an abnormal Pap? Y N Details: _____

When was your last mammogram? _____ Was it normal? Y N

Do you perform monthly breast exams? Y N

Do you use contraception? Y N Type:_____

Do you have frequent vaginal infections? Y N Yeast Herpes Other:_____

Do you have endometriosis? Y N Do you have ovarian cysts? Y N

Have you had breast, cervical, uterine, or ovarian cancer? Y N Details:_____

Please list the number of: Pregnancies_____ Live births____Abortions/Miscarriages____ Living Children_____

I have answered the questions truthfully and to the best of my knowledge, and I have not omitted any other medical problems for which I have been treated in the past.

_____ _____

Signature Date