Medical History Form

Name: _____ **Birth Date:** ___/____/_____ **Date:** ___/____/_____

Person completing the form: _____ **Relationship:** _____

Thank you for taking the time to complete this valuable information. This allows us to provide the best care possible for our patients. Feel free to use additional pages to write any information not included here that you think is important.

Main reason for visit: _____

Current/Past Medical Problems: Example Strokes, Heart problems, High Blood Pressure, High Cholesterol, etc.

Current or Past Medical Problem	Approximate date of onset or diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Past Surgeries: Example Gall Bladder removed, Cataract surgery, Heart surgery, Colonoscopy, etc.

Past Surgery	Approximate Date of Surgery
1.	
2.	
3.	
4.	

Recent Hospitalization: Please list the reason for any recent hospitalizations in the past 2 years.

Reason for Hospitalization	Name of Hospital	Date

Medications: ***Please list both prescription and over the counter medications.***

Medication and Strength (mg or mcg, etc.)	How much is taken and how often or As Needed
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Preferred Pharmacy: _____ **Phone number:** _____

Address/Zip Code: _____

Allergies and Reactions: Example rash, swelling, trouble breathing, etc.

Medicine/Product Allergic To	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

Immunizations: Please mark the appropriate box below and list dates in known.

Immunization	Yes	Date	No
Influenza (Flu)			
Pneumococcal (Pneumonia)			
Shingles			

Family History: Please list medical problems of close family members (example Dementia, Cancer, Heart Disease, Depression), also list if anyone has died, the age of death, and the cause of death.

Family Member	Medical Problems or Cause of Death	Alive or Age of Death
Father		
Mother		
Brother		
Sister		

Social History:

- **Tobacco Use:** Never □ Quit □ Current Smoker □
  Packs per day on average: _____ Years smoked: _____
  Quit Date: _____ Type: Cigarette □ Cigar □ Pipe □

- **Smokeless Tobacco:** Never Used □ Quit □ Current User □ Unknown □

- **Alcohol Use:** None □ Number of drinks per week: _____
  Was drinking too much alcohol ever a problem for you? Yes □ No □

- **Illegal Drug Use:** No □ Yes □ Type: _____

- **Sexual Activity:** Not currently □ No □ Yes □

- **Past Occupation:** _____

- **Highest level of Education:** _____**Years of Education:** _____

- **Religion/Faith:** _____

- **Primary Caregiver:** _____ **Relationship:** _____
  Phone Number: _____

- **Advance Directives:** Durable Power of Attorney for Healthcare □
  Name: _____ Relationship: _____
  Living Will □ Do Not Resuscitate Form □

  If you have any of the above documents please have a copy of them made for us to place in your chart.

Review of Systems: Please check or describe below any of the following symptoms you may be having:

- **General:** Fever □ Chills □ Weight Loss □ Fatigue □ Sweating □ Weakness □
- **Skin:** Rash □ Location: _____ Itching □ Bed Sore □ Location/Dressing: _____
- **Head:** Headaches □ Hearing Loss □ Hearing aide □ Ringing in ears □ Ear pain □ Ear discharge □ Nose bleeds □ Nose congestion □ Sore throat □ Last Dental Exam: _____
- **Eyes:** Blurred Vision □ Double Vision □ Light Sensitivity □ Eye Pain □ Eye discharge □ Eye Redness □ Last Eye Exam: _____ Eye Doctor: _____
- **Heart:** Chest pain □ Palpitations □ Trouble breathing lying flat □ Leg cramps □ Leg Swelling □
- **Lungs:** Cough □ Mucus production □ Shortness of breath □ Wheezing □ On Oxygen □ Continuous □ Nightly Only □ Flow rate: _____
- **Gastrointestinal:** Heart burn □ Nausea □ Vomiting □ Abdominal pain □ Diarrhea □ Constipation □ Blood in stool □ Stool Incontinence □
- **Genitourinary:** Urinary burning □ Urgency □ Frequency □ Blood in urine □ Incontinence □
- **Musculoskeletal:** Muscle aches □ Neck pain □ Back pain □ Joint pain □ Location: _____
- **Endocrine:** Easy bruising □ Environmental allergies □ Extreme thirst □ If diabetic, testing frequency? ____ Morning sugar range: _____ Evening sugar range: _____
- **Neurological:** Dizziness □ Tingling □ Tremor □ Sensory change □ Speech change □ Difficult/Trouble swallowing □ Weakness on one side of body from stoke □ Seizures □ Loss of consciousness □
- **Psychiatric:** Depression □ Suicidal thoughts □ Substance abuse □ Hallucinations □ Insomnia □ Nervous/Anxious □ Memory loss □

Durable Medical Equipment: Please list any medical equipment you have, such as a bedside commode, wheel chair, oxygen, hospital bed, etc. Please also list the supplier and their phone number.

Name of Equipment	Supplying Company	Company Phone Number
1.		
2.		
3.		
4.		

Recent Healthcare Providers: Please list any recent medical providers (doctors, nurse practitioners, physician assistants), their specialty, phone number, and date of last visit.

Provider Name	Specialty	Phone Number	Date of Last Visit

Please have this information completed prior to the first visit to give to the provider. If preferred, this form may be faxed to INhouse Primary Care at 317-324-4073.