PERSONAL MEDICAL HISTORY

DATE _____

LAST NAME _____ FIRST _____ MIDDLE _____ BIRTH DATE _____

1. List the main complaints and their duration which brought you to the doctor:

_____

_____

REVIEW OF SYSTEMS

2. Check any of the following symptoms you have had recently:

YES	NO		YES	NO	
		Weight Gain / Loss			Coughing Spells / Wheezing
		Fever, Chills, or Night Sweats			Persistent Cough / Coughing Blood
		Fatigue or Lack of Energy / Appetite			Hoarseness / Postnasal Drip
		Any Place on Skin that Worries You			Gum or Teeth Trouble
		Painful Fingers When They Get Cold			Sore Throat / Fever / Ulcers
		Joint Pain or Swelling / Leg Cramps			Trouble or Pain when Swallowing
		Neck Pain or Stiffness			Vomiting of Blood
		Easy Bruising			Pain in Abdomen (“stomach”) / Indige / Gas
		Nosebleed			Diarrhea
		Enlarged or Painful Glands (“Kernels”)			Pain in Rectum with Bowel Movement
		Double Vision / Poor Vision			Fainting
		Pain in Eyes			Black or Terry Bowel Movement
		Ringing in Ears / Hard of Hearing			Red Blood or Mucus in Bowel Movements
		Numbness or Shooting Pain in Arms or Legs			Urinating Frequently at Night
		Headache / Dizziness			Difficulty Passing Your Urine
		Chest Pain or Discomfort			Blood in Your Urine
		Smothering Spells at Night			Difficulty Related to Sexual Function
		Fast Heartbeat			Excessive Thirst / Appetite
		Swelling of Ankles			Sadness / Crying Spells
		Shortness of Breath			Excessive Worry / Short Temper
		Cramping Pain in Calf Muscles When Walking			Unable to Sleep Well

3. Have you ever had any of the following?

YES	NO		YES	NO	
		Food Allergy			Hepatitis or Other Liver Disease
		Skin Disease / Hives			Gallbladder Disease
		Arthritis			Hemorrhoids
		Back Trouble / Rupture Disc			Hernia
		Gout			Kidney Problems
		Blood Disease or Anemia / Bleeding			(Type)
		Blood Transfusion			Prostate Trouble
		Cancer			High Blood Pressure
		Eye Disease			Diabetes
		Deafness			Goiter or Thyroid Disease
		Stroke or Paralysis			Measles (Type)
		Epilepsy			Scarlet Fever
		Nervous Disorder			Chicken Pox
		Heart Disease or Heart Attack / Murmur			Pneumonia / Pleurisy
		Rheumatic Fever			STD
		Varicose Veins / Phlebitis / Clots			**Females**
		Tuberculosis or TB Skin Test			Start Menstruation
		Chronic Lung Trouble / Asthma / Emphysema			Trouble Bleed
		Ulcer			Days of Period / Different

Patient Name: _____

4. What surgery or operations have you had?

SURGERY	AGE OR DATE	HOSPITAL OR CITY
EXAMPLE: Tonsillectomy	Age 12	General Hospital, New Orleans, LA

5. Have you ever been hospitalized for anything other than surgery, accident, or child birth?

ILLNESS	AGE OR DATE	HOSPITAL OR CITY
EXAMPLE: Pneumonia	1965	General Hospital, New Orleans, LA

6. Females:

Age you started your Menstruation? _____

Any Trouble Bleeding? _____

Days of Period and are they different? _____

7. Have you ever broken any bones? _____ If YES, which bones and when?

_____

_____

8. Have you ever had a concussion or head injury? _____

9. List any medications or foods you are sensitive to or allergic to:

_____

_____

_____

10. List any medications you are taking now:

_____

_____

_____

11. Have you ever had penicillin? _____

12. When was the last time you had an x-ray of your chest? _____

13. Have you ever been turned down for life insurance, military service, or employment because of health problems?

_____

_____

_____

14. Have you ever been disabled? _____

Patient Name: _____

FAMILY HISTORY

15. Were your parents related to each other when married? (For **example**: Third cousings that married.) _____

Are there any known or suspected inherited diseases in your family? (For example: Sickle cell disease or muscular dystrophy)

_____

_____

Has anyone in your family had a child with a birth defect? (For example: Cleft lip or heart disease at birth)

_____

_____

16. Has a mother, father, brother or sister ever had?

YES	NO		RELATIONSHIP
		Cancer	
		Heart Trouble	
		Diabetes	
		Stroke	
		High Blood Pressure	
		Glaucoma	
		Migraine Headache	
		Peptic Ulcer	
		Bleeding Tendency	
		Gout	
		Psoriasis	
		Epilepsy	

17. FATHER: Alive _____ Age _____ State of Health _____

Dead _____ Age _____ Cause of Death _____

MOTHER: Alive _____ Age _____ State of Health _____

Dead _____ Age _____ Cause of Death _____

Number of Brothers: Living _____ Dead _____

Age and Cause of Death of each who died: _____

_____

_____

Number of Sisters: Living _____ Dead _____

Age and Cause of Death of each who died: _____

_____

_____

Number of Children: Living _____ Dead _____

Age and Cause of Death of each who died: _____

AGE	SEX	ILLNESS

Patient Name: _____

SOCIAL HISTORY

18. I am: Married _____ Single _____ Divorced _____ Widowed _____

19. Occupation: _____

20. How often do you take vacation? _____

21. How many people do you live with? _____

22. To what grade in school did you attend? _____

23. How much exercise do you do? None _____ A little _____ Some _____ A Lot _____

24. Do you smoke? _____

Drink Alcohol? _____

25. What do you do for fun? _____

26. Do you attend Church? _____ What religion? _____

27. Please note any medical problem not covered in the previous questions that you would like to discuss with your physician. Thank you for your cooperation.

_____

_____

_____

_____

Have you ever been addicted to drugs? If so, when and to what drugs? i.e. alcohol, cocaine, pain pills, etc. _____

Are you now taking addictive or habituating drugs? If so, what drugs? _____

Do you wish assistance with stopping drug usage? _____

Thank you for completing the medical history form as this will help us to better serve you. We appreciate the opportunity of being your new Physician and in providing you with quality medical care. We would also like to take this time to let you know of a few office policies and please let us know should you have any questions.

- We often provide same day appointments if you call by 9:00 am. This generally applies when you are sick but this is a great thing to remember should you need to get in quickly.
- Alternative Contact Form-please complete this should you want another person to have access to your medical information. This means that the staff of Family Medical Center are permitted to speak to the person you list on your behalf should you not be available. Remember to notify us should you wish to remove this person from receiving such information.
- Payment is expected at the time of service and this includes payment for any outstanding balances.
- Medication Refills take up to 48 hours to handle, so please make sure you have enough medication during this time. Refills for controlled medications are authorized at the discretion of the Physician and only by the Physician who originally prescribed the controlled drug.
- Please notify us should you be unable to keep a scheduled appointment as this allows for another patient to take that time.

_____

Patient Signature