

MEDICAL HISTORY FORM

Today's date: _____

Name: _____ Gender: Male Female

Ethnicity: Hispanic/Latino Other

Race: White Black Other Asian Hispanic North American Native

Insurance Name: _____ Insurance Card #: _____

Phone #: _____ Cell Phone #: _____

DOB: _____ e-mail Address: _____

Are you registered for MedFusion? Yes No

What medical problems do you have? (Example: Diabetes, Hypertension, Congestive Heart Failure, Chronic Low Back Pain, Arthritis of the Right Knee, Cancer of the Breast). Please indicate **all** problems below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

What surgery have you had? What date was it done? (Example: Gallbladder removed by laparoscopy, Feb. 2004; Coronary artery bypass graft – 5 vessels, Summer 2006; Splenectomy, vaginal hysterectomy and both ovaries removed, 5/1/02; Abdominal hysterectomy and the right ovary removed, 1970).

SURGERY	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you ever been admitted to the hospital? Yes No If yes, where, date & reason:

WHERE	DATE	REASON
1.		
2.		
3.		
4.		
5.		
6.		

What medications do you take? Include all over-the-counter medications. (Example: Simvastatin 20 mg once a day, Enalapril 10 mg two times a day, Aspirin 81 mg once a day, Niacin 500 mg once a day, vitamin once a day)

MED	DOSE	HOW OFTEN	WHO PRESCRIBED
1. Example: Enalapril	10 mg	Two times a day	Dr. Smith
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

What allergies do you have? What happens? (Example: Penicillin – shortness of breath, Sulfa – rash, Latex, rash).

ALLERGIES	REACTION
1.	
2.	
3.	
4.	
5.	

List all the Physicians you see. (Example: Dr. Kenneth Johnson - Family Medicine, Dr. David Williams - Cardiology, Dr. Vinod Patel - Nephrology, Dr. Pamela Carbiener – OB/GYN).

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Name: _____

Please tell us about specific family members: Adopted – Family History Unknown

This will help us evaluate your future risk factors. Important diseases to include are Hypertension, Diabetes, Heart Disease, Kidney Disease, Types of Cancer, Bleeding Problems, Endocrine Problems, Neurologic Disease, Mental Health Diseases or Rheumatology Diseases like Lupus or Rheumatoid Arthritis.

Father: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

(Examples: Hypertension, Diabetes, cancer of the breast, cancer of the colon).

Mother: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Paternal Grandfather: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Paternal Grandmother: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Maternal Grandfather: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Maternal Grandmother: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Brother #1: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Brother #2: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Brother #3: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Sister #1: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Sister #2: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Sister #3: Living Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

Maternal Aunt #1 _____ Medical problems: _____

Maternal Aunt #2 _____ Medical problems: _____

Maternal Uncle #1 _____ Medical problems: _____

Maternal Uncle #2 _____ Medical problems: _____

Paternal Aunt #1 _____ Medical problems: _____

Paternal Aunt #2 _____ Medical problems: _____

Paternal Uncle #1 _____ Medical problems: _____

Paternal Uncle #2 _____ Medical problems: _____

# Children		Medical problems:

Please tell us about yourself.

Current occupation: _____

Retired Disabled Student Never worked

Marital status: Currently married
 Divorced _____ times
 Never married
 Separated
 Single
 Widowed

Name: _____

EDUCATION

Highest level of education achieved: _____
 Currently in school Grade _____
 Doing well in school Having difficulty in school
 Not able to read Not able to write

TOBACCO

Never smoked
 Have you smoked at least 1 cigarette in the last 6 months? Yes No
 Smoked _____ packs for _____ years
 Quit smoking on _____
 (Date)

ALCOHOL

No alcohol in the last 12 months
 Recovering alcoholic
 Drink _____ beers per week.
 Drink _____ glasses of wine per week.
 Drink _____ shots of liquor per week.
 Have you ever felt you should cut down on your drinking? Yes No
 Have people annoyed you by criticizing your drinking? Yes No
 Have you felt guilty about your drinking? Yes No
 Have you ever had a drink in the morning to steady your nerves or get rid of a hangover? Yes No
 Have you had an accident or broken a bone due to drinking? Yes No

OTHER SUBSTANCES

Use marijuana How often _____
 Use cocaine How often _____
 Use of street drugs – what _____ How often _____

BIRTH CONTROL METHOD

Don't use birth control
 Trying to get pregnant
 Tubal ligation
 Vasectomy
 Birth control pills or patch
 IUD
 Injection
 Hysterectomy
 Abstaining
 Condoms

FEMALES:

Date of Last Pap Smear: _____
 Have you ever had an abnormal pap? Yes No
 Date of Last Mammogram: _____

Have you ever had a blood transfusion? Yes No
 If yes, date of transfusion: _____

SEXUAL HISTORY

Heterosexual Homosexual Bisexual
 # of partners in the last year? _____
 # of partners in your lifetime? _____
 History of sexual abuse or rape? Yes No

Name: _____

DIET

Do you eat at least 5 fruits or vegetables a day? Yes No

Have you had a weight change greater than 10 lbs in the last month? Yes No

EXERCISE

What exercise do you do?

(Example: Walk 1 mile 3 days a week, water aerobics 1 hour once a week, go to the gym and lift weights 30 minutes 3x/wk).

1. _____
2. _____
3. _____
4. _____

Do you have a caregiver? Yes No

If so, who is your caregiver: Name: _____
Phone: _____ Cell: _____
e-mail: _____

Caregiver on site: _____ days/week

Caregiver on site: _____ hours/day

What is your native language? _____

What other languages do you speak? _____

LIVING ARRANGEMENTS

- Private residence own rent
 Apartment
 Assisted Living
 Nursing Home
 Hospice

Number of people living with you _____

Do you drive? Yes No

Do you use a Cane Walker Wheelchair

Do you have an Advance Directive? Yes No

Would you like more information on Advance Directives? Yes No

Who is your Power of Attorney? _____

PREVENTIVE

Have you had a colonoscopy? Yes No

If yes, where? _____ Date: _____

Have you had a Bone Density? Yes No Date: _____

Did you have chicken pox disease? Yes No Date: _____

Have you had a Pneumonia shot? Yes No Date: _____

Have you had a Tetanus shot? Yes No Date: _____

