Forum Family Medicine Medical History

Name_______________________________________ Date of birth:______ Date:_____

Medication Allergies Drug **and type of reaction**

____
____
____
____

Medications– prescription and vitamins/supplements +doses

____
____
____
____

Surgeries *Check and note year*

Appendix	Knee/hip/shoulder
Biopsy	Tonsils
Hernia	Vasectomy
Hysterectomy	Other:_____________

Hospitalizations *List **any** stays in the hospital overnight not already listed*

Year Reason for hospitalization (type of illness or injury)

____
____
____

Medical Conditions seen or treated by a physician

√	Eye problems	√	Endocrine/glands	√	Stomach/intestinal	√	Neurologic	√	Blood problems	√	Bone/joint
	Cataracts		Adrenal problem		Colitis / Diverticulitis		Migraine		Anemia		Gout
	Glaucoma		Diabetes		Colon polyps		Multiple sclerosis		Blood clots		Osteoarthritis
	Retina problem		Thyroid problems		Heartburn / Acid reflux		Pinched nerve		Excess bleeding		Rheumatoid arthritis
	Other		**Lung problems**		Irritable bowel syndrome		Seizure		High cholesterol		Fractures
	Ear problems		Asthma		Ulcer		Stroke/TIA		**Male problems**		Severe sprains
	Frequent infections		Chronic bronchitis		**Urinary**		Vertigo/dizziness		Enlarged prostate		**Other**
	Hearing loss		Emphysema		Bladder control problem		**Psychiatric**		Erection problem		Cancer
	Nose problems		Pneumonia		Infections– kidney		Anxiety		Prostate infection		High blood pressure
	Allergies		**Heart problems**		Kidney stones		Attention deficit		**Female problems**		Liver problems/hepatitis
	Deviated septum		Heart attack		**Infection problems**		Bipolar		Abnormal PAP		Obesity
	Chronic congestion		Heart failure		HIV/AIDS		Depression		Breast lump/discharge		Osteoporosis
	Frequent infections		Heart murmur		STDs		Insomnia		Heavy/irregular periods		Skin conditions
	Nosebleeds		Irreg heartbeat		Tuberculosis		Suicide attempt		Miscarriage		Sleep apnea/ snoring

Family History (mark all that apply for **blood relatives**)

	Father	Mother	Siblings	Father's Parents	Mother's Parents
AGES:	_____	_____	________		
Alcoholism					
Asthma/allergies					
Cancer (what type?)					
Diabetes					
Glaucoma					
Heart disease					
High blood pressure					

	Father	Mother	Siblings	Father's Parents	Mother's Parents
Kidney disease					
Mental illness					
Migraine					
Osteoporosis					
Stroke					
Thyroid disease					
Other___________________________________					

Social History

Marital status: single married divorced separated widowed Number of children:_______

Who do you live with? ____________________________

Patient work status: student retired unemployed employed/ occupation: __________________________

Habits	Never	In past	Currently	How much per day	Does it cause you problems?_____		
Smoking				_____ cigs/packs	no	yes	I want to quit
Alcohol				_____ drinks day/wk	no	yes	I want to quit
Caffeine				_____ cups/pops	no	yes	I want to quit
Drugs				_______________	no	yes	I want to quit

Immunizations:(year) Tetanus/pertussis _______ Pneumonia _______ Shingles ________

Do you have a **Living Will or Advanced Directives** (in case of serious illness): Yes No I would like info on this