

**MEDICAL HISTORY FORM**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: □MALE □FEMALE Present Health: □Excellent □Good □Fair □Poor

**MEDICATIONS**

All prescription, non-prescription, vitamins, and herbal supplements

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| **NAME** | **DOSE** | **HOW OFTEN?** | **DATE STARTED** |
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**ALLERGIES**

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| **LIST ALL ALLERGIES/REACTIONS** |  |

**SOCIAL HISTORY**

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| --- | --- | --- |
| **YES** | **NO** |  |
|  |  | Marital Status: □Single □Married □Divorced □Widowed □Other |
|  |  | Who lives at home with you? |
|  |  | Do you have an end of life directive? |
|  |  | Do you have any children? |
|  |  | Have you ever smoked or used tobacco?  Tobacco Use (type and frequency): |
|  |  | Alcohol Use (type and frequency): |
|  |  | Caffeine Intake (cups per day): |
|  |  | Recreational Drugs: |

**FAMILY HEALTH HISTORY**

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| **MEMBER** | **CURRENT DISEASES** | **OVERALL HEALTH** | **AGE** | **DECEASED** | **CAUSE OF DEATH** |
| **FATHER** |  |  |  |  |  |
| **MOTHER** |  |  |  |  |  |
| **BROTHER/SISTER** |  |  |  |  |  |
| **GRANDFATHER/**  **GRANDMOTHER** |  |  |  |  |  |
| **LIST SIGNIFICANT FAMILY DISEASES** |  |  |  |  |  |

**FAMILY MEDICAL HISTORY**

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| **Check and indicate relationship**   |  |  |  | | --- | --- | --- | | □ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Blood Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Obesity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Drug/Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type: | □ Other: | |

**PERSONAL MEDICAL HISTORY**

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| **Immunizations and Date Completed:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | □ Hepatitis A Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Measles Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Rubella Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Zostervax (Shingles) Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Pneumonia Date\_\_\_\_\_\_\_\_\_\_\_\_ |  | | □ Hepatitis B Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Polio Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Varicella Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Tetanus Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Flu  Date\_\_\_\_\_\_\_\_\_\_\_\_ |  |   **Surgical History and Date Completed:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | □ Appendectomy Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Open Heart Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Hysterectomy Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Heart Cath  Date\_\_\_\_\_\_\_\_\_\_\_\_ | | | □ Gall Bladder Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Tonsillectomy Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Hernia Repair Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Other:  Date\_\_\_\_\_\_\_\_\_\_\_\_ |   **Past Hospitalizations (Reason and Date):**   |  |  |  | | --- | --- | --- | | □  Date\_\_\_\_\_\_\_\_\_\_\_\_ | □  Date\_\_\_\_\_\_\_\_\_\_\_\_ | □  Date\_\_\_\_\_\_\_\_\_\_\_\_ |   **Other Physicians and Specialties:**   |  |  |  | | --- | --- | --- | | Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **Past Medical History (diagnosis, dates):**   |  |  |  |  | | --- | --- | --- | --- | | □ Transfusion Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Heart Problems | □ Blood Pressure | | | □ Diabetes □type I □ type II  Are you treated with insulin? | □ Elevated Cholesterol/ Lipids | □ Cancer  Type: | | | □ Stroke | □ Eye, Ear, Nose or Throat Problems | □ Lung | | | □ Gastrointestinal  Date of Colonoscopy/Results? | □ Kidney or Bladder | □ Neurologic | | | □ Skin | □ Bone/Muscle/Joint | □ Thyroid or other Endocrine | | | □ Blood Disorders | □ Depression/ Anxiety  Other: | □ Suicide Attempt | | | □ MALE: Prostate/ Sexual dysfunction  Date of Last PSA & results: | □ FEMALE: Gynecological | □ FEMALE: Abnormal Breast Symptoms | | | □ FEMALE: Date of Last Mammogram & Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ever Abnormal? Breast Implants?  Date of Last Pap Smear & Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ever Abnormal? | | | | □ Other: | | | | | |





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| ***Current Patient Symptoms***  Please indicate (X) Current Symptoms and please provide details   |  | | --- | | **HEAD/NECK** | | □ Headache | | □ Migraine | □ Concussion | | □ Head Injury | | □ Seizures | □ Dizzy Spells | | □ Fainting | | □ Light Headedness | □ Memory Loss | | □ Wears Glasses | | □ Wears Contacts | □ Blindness: LEFT RIGHT | | □ Color Blind | | □ Double Vision | □ Cataracts | | □ Hearing Loss | | □ Ear Ringing/ Tinnitus | □ Wears Hearing Aid: LEFT RIGHT | | □ Environmental Allergies  Trigger: | | □ Skin Allergies  Trigger: | □ Sinus Congestion/ Allergy Related Symptoms | | □ Poor Teeth | | □ Toothaches | □ Bleeding Gums | | □ Mouth Sores | | □ Hot/Cold Intolerance | □ Other: |  |  | | --- | | **CHEST** | | □ Chest Pain/ Discomfort | | □ Palpitations | □ Shortness of Breath- At Rest | | | □ Shortness of Breath- With Exercise | | □ Cough | □ Cough Up Blood | | | □ Wheeze- At Rest | | □ Wheeze- With Exercise | □ Breast Lump or Changes | | □ Breast Tenderness | | □ Nipple Discharge | □ Other: |  |  | | --- | | **THROAT** | | □ Mouth Dryness | | □ Hoarseness | □ Sore throat | | □ Swollen Glands | | □ Other: |  |  |  | | --- | | **GASTROINTESTINAL** | | □ Nausea | | □ Vomiting | □ Diarrhea | | | □ Constipation- Frequency: | | □ Change in Bowel Habits | □ Abdominal Pain | | | □ Abdominal Fullness/ Bloating | | □ Hernia | □ Bloody or Tarry Stools | | □ Hemorrhoids- Internal | | □ Hemorrhoids- External | □ Acid Reflux | | □ Other: | |  |  |  |  | | --- | | **URINARY** | | □ Burning with Urination | | □ Frequency of Urination | □ Urinary Incontinence | | □ Difficulty Starting Stream | | □ Increased Urination at Night | □ Inability to Empty Bladder |  |  | | --- | | **MUSCULOSKELETAL** | | □ Muscle/ Joint Pain | | □ Muscle/ Joint Stiffness | □ Fracture or Broken Bone | | □ Limitation in Motion | | □ Numbness or Tingling | □ Weakness |  |  | | --- | | **SKIN** | | □ Rash | | □ Mole/Skin Lesion | □ Bruise/ Bleed Easily | | □ Skin Cancer | | □ Other: |  |   ***Current Patient Symptoms Cont.***   |  | | --- | | **OTHER** | | □ Unexplained Weight Loss | | □ Unexplained Weight Gain | □ Excessive Thirst | | □ Night Sweats | | □ Weakness | □ Fever/chills | | □ Mood Swings | | □ Anxiety | □ Depression | | □ Insomnia- Can’t Fall Asleep | | □ Inability to Stay Asleep | □ Daytime Sleepiness | | □ Snoring | | □ Does Snoring Wake You? | □ Do You Stop Breathing For Periods of Time When Asleep |  |  | | --- | | Are You Sexually Active? □ YES □ No Method of Birth Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are You Pregnant? □ YES □ No | | Do You Have Any Sexual Concerns? □ YES □ No | | Females: Date of Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unusual vaginal bleeding? □ YES □ No | | Males: Prostate Problems? □ YES □ No | | Please Provide Any Other Information You Feel Your Physician Should Be Aware Of: |  |  | | --- | | **EXERCISE ASSESSMENT** | | Do you have a gym membership? □ YES □ No  Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Do you have gym equipment at home? □ YES □ No  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Do you work with a personal trainer? □ YES □ No  Trainer Name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | | What type of cardio exercises do you do?  How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | What type of strength (weight) training do you do?  How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Do you have any barriers to exercise? | | Do you have any fitness goals? |   *The above information is accurate and complete to the best of my knowledge.*  **Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Reviewer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Reviewer Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

