

**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**

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

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**PERSONAL MEDICAL HISTORY**

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| **Immunizations and Date Completed:**

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| --- | --- | --- | --- | --- | --- |
| □ 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):**

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| --- | --- | --- |
| □ Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Date\_\_\_\_\_\_\_\_\_\_\_\_ | □ Date\_\_\_\_\_\_\_\_\_\_\_\_ |

**Other Physicians and Specialties:**

|  |  |  |
| --- | --- | --- |
| Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Past Medical History (diagnosis, dates):**

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| □ 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 dysfunctionDate 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

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| **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:  |

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| **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:  |

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| **THROAT** |
| □ Mouth Dryness  | □ Hoarseness  | □ Sore throat  |
| □ Swollen Glands  | □ Other:  |  |

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| **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:  |  |  |

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| **URINARY** |
| □ Burning with Urination  | □ Frequency of Urination  | □ Urinary Incontinence  |
| □ Difficulty Starting Stream  | □ Increased Urination at Night | □ Inability to Empty Bladder  |

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| **MUSCULOSKELETAL**  |
| □ Muscle/ Joint Pain | □ Muscle/ Joint Stiffness | □ Fracture or Broken Bone  |
| □ Limitation in Motion  | □ Numbness or Tingling  | □ Weakness  |

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| **SKIN**  |
| □ Rash  | □ Mole/Skin Lesion  | □ Bruise/ Bleed Easily  |
| □ Skin Cancer  | □ Other:  |  |

***Current Patient Symptoms Cont.***

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| **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  |

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| --- |
| 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:  |

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| **EXERCISE ASSESSMENT**  |
| Do you have a gym membership? □ YES □ NoWhere? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Do you have gym equipment at home? □ YES □ NoType: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you work with a personal trainer? □ YES □ NoTrainer 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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

