



MEDICAL & FAMILY HISTORY FORM

TODAY'S DATE: _____/_____/_____

NAME: _____ DATE OF BIRTH: _____/_____/_____

Chief Complaint: _____

Medications - Please list all of your current prescription and non-prescription medications. (ex: vitamins and supplements)

Medication Name:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: None Penicillin Sulfa Aspirin Iodine Latex Others: _____

Description of allergic reaction: _____

Past Medical History

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> GERD (Reflux) | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> GI Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> COPD | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Neurologic Disorders | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Depression | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Chronic anxiety | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Fatty liver | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Colon cancer | | | | |

Previous Hospitalizations

Reason:	Date:
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries/Procedures

- | | | | | | |
|--|-------------|--|-------------|--|-------------|
| <input type="checkbox"/> Appendectomy | Date: _____ | <input type="checkbox"/> Heart bypass | Date: _____ | <input type="checkbox"/> Radiation Therapy | Date: _____ |
| <input type="checkbox"/> Barium Enema | Date: _____ | <input type="checkbox"/> Heart valve Replacement | Date: _____ | <input type="checkbox"/> Sigmoidoscopy | Date: _____ |
| <input type="checkbox"/> Breast Surgery | Date: _____ | <input type="checkbox"/> Hemorrhoid surgery | Date: _____ | <input type="checkbox"/> Small Bowel Resection | Date: _____ |
| <input type="checkbox"/> Capsule Endoscopy | Date: _____ | <input type="checkbox"/> Hiatal hernia repair | Date: _____ | <input type="checkbox"/> Stomach Surgery | Date: _____ |
| <input type="checkbox"/> Cholecystectomy | Date: _____ | <input type="checkbox"/> Hysterectomy | Date: _____ | <input type="checkbox"/> Thyroid Surgery | Date: _____ |
| <input type="checkbox"/> Colon surgery | Date: _____ | <input type="checkbox"/> Joint replacement | Date: _____ | <input type="checkbox"/> Tonsillectomy | Date: _____ |
| <input type="checkbox"/> Colonoscopy | Date: _____ | <input type="checkbox"/> Kidney Surgery | Date: _____ | <input type="checkbox"/> Tubal ligation | Date: _____ |
| <input type="checkbox"/> Colostomy | Date: _____ | <input type="checkbox"/> Liver biopsy | Date: _____ | <input type="checkbox"/> Ulcer Surgery | Date: _____ |
| <input type="checkbox"/> C-section | Date: _____ | <input type="checkbox"/> MRI | Date: _____ | <input type="checkbox"/> Ultrasound | Date: _____ |
| <input type="checkbox"/> CT Scan | Date: _____ | <input type="checkbox"/> Obesity surgery | Date: _____ | <input type="checkbox"/> Upper GI Series X-ray | Date: _____ |
| <input type="checkbox"/> EGD | Date: _____ | <input type="checkbox"/> Ovarian Surgery | Date: _____ | <input type="checkbox"/> Uterine Surgery | Date: _____ |
| <input type="checkbox"/> ERCP | Date: _____ | <input type="checkbox"/> Pacemaker Placement | Date: _____ | <input type="checkbox"/> None | Date: _____ |
| <input type="checkbox"/> Gallbladder Surgery | Date: _____ | <input type="checkbox"/> Prostate (TURP) | Date: _____ | <input type="checkbox"/> Other: _____ | |



MEDICAL & FAMILY HISTORY FORM

Healthy/Alive	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Deceased	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Colon polyps	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Colon cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Gastric/ulcer disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Liver disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Pancreas disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Crohn's disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Ulcerative colitis	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Stomach cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Diabetes mellitus	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Heart attack	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Breast cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters
Other cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters

Social History

Marital status: single married divorced widowed separated domestic partner

Occupation: _____ unemployed retired student

Smoking history: never yes; _____ packs per day for _____ years; Quit (how long) _____

Alcohol use: no yes; amount per day: _____ for _____ years

Drug use: no yes; specify drugs and amounts: _____

Exercise habits: no yes; how much and how often: _____

Do you have any tattoos? no yes

Do you have any piercings? no yes

Recent travel outside US: no yes; where: _____

Caffeine use: no yes; details: _____

Date of last Pneumovax: _____ **Date of last flu shot:** _____

Review of Systems—check all that apply at the present time

General-

- chills
- fever
- loss of appetite
- night sweats
- weight gain
- weight loss
- feeling tired or poorly

Eyes-

- worsening of vision
- blurred vision
- vision distortion
- eye pain

Otolaryngeal Systems-

- earache
- nasal discharge
- mouth sores
- bleeding gums
- hoarseness
- throat pain
- facial pain
- sinus pain

Cardiovascular-

- chest pain/discomfort
- fast heart rate
- swelling of legs
- varicose veins

Pulmonary-

- cough
- wheezing
- shortness of breath

Gastrointestinal-

- abdominal swelling/pain
- belching
- black stools
- red blood in bowel movement
- change in bowel movement frequency
- constipation
- diarrhea
- difficulty swallowing
- fatty food intolerance
- full after eating small meals
- gas/bloating
- heartburn
- hemorrhoids
- yellow skin or eyes
- nausea
- pain with swallowing
- decrease in appetite
- rectal pain/bleed
- regurgitation of food
- incontinence of stool
- vomiting
- vomiting blood

Musculoskeletal-

- joint pain
- joint stiffness
- swollen joints
- low back pain
- muscle pain

Skin Symptoms-

- Pruritis (itching)
- skin lesions
- rashes

Neurologic-

- numbness or tingling
- dizziness/lightheadedness
- vertigo
- headaches
- weakness in arms or legs
- blurred vision
- memory lapses or loss

Psychiatric-

- anxiety
- depression
- panic attacks
- loss of sleep

Endocrine-

- heat or cold intolerance
- excessive thirst or urination
- hot flashes

Hematologic/Lymphatic-

- easy bruising tendency
- swollen glands
- nosebleeds

Urinary-

- pain or difficulty with urination
- frequent urination
- blood in urine
- incontinence of urine

Genitoreproductive-Female

- vaginal discharge
- heavy periods
- date of last period: _____

Genitoreproductive-Male

- discharge from penis
- testicular pain
- testicular lump