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| **COMPREHENSIVE MEDICAL HISTORY** |
| This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your written consent. Thank you for taking the time to complete this lengthy form. Completion of this history allows us to provide you the most complete medical care possible and will be reviewed during your visit. |
| GENERAL |  |
| Name: | Birthdate: | SSN: |
| Marital Status: | Occupation: |
| Previous Primary Care Provider: |
|  |
| MEDICATIONS |  |
| Please list any prescription and over-the-counter medications you are taking, as well as any herbs, vitamins, or nutritional supplements. Please include the dosage amount, and how often you take them daily. |
| 1) | 6) | 11) |
| 2) | 7) | 12) |
| 3) | 8) | 13) |
| 4) | 9) | 14) |
| 5) | 10) | 15) |
| MEDICAL HISTORY | (Check all that apply) |

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| --- | --- | --- | --- |
| **□** High blood pressure | □ Heart Attack | □ Seizures/Epilepsy | **□** Cancer (List Type) |
| **□** High cholesterol | □ Overactive bladder | □ AIDS/HIV |
| **□** Thyroid problems | □ Migraines | □ Addiction (Drug/Alcohol) |
| **□** Diabetes | □ Asthma | □ Kidney disease | **□** Other (please list) |
| **□** Stroke | □ COPD | □ Chicken Pox/Herpes |
| **□** Blood clots | □ Liver disease/Hepatitis | □ Mononucleosis |
| ALLERGIES | Please list any drug, food or environmental substances that you are allergic to or have had a bad reaction to. |

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| SURGICAL HISTORY |  |
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|  **/ /** |  |  **/ /** |  |
|  **/ /** |  |  **/ /** |  |
|  **/ /** |  |  **/ /** |  |
| FAMILY HISTORY |  |
|  | BIRTHDATE / AGE AT DEATH |  | BIRTHDATE / AGE AT DEATH |
| MOTHER |  | DAUGHTER (s) |  |
| FATHER |  |  |  |
| BROTHER(s) |  | SON(s) |  |
| SISTER(s) |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FAMILY HISTORYPlease put an “X” in the box if the relative has any of the following: | HIGH BLOOD PRESSURE | HIGH CHOLESTEROL | DIABETES | THYROID DISEASE | OBESITY | STROKE | EPILEPSY/SEIZURES | PARKINSONS DISEASE | ANEMIA | LEUKEMIA | KIDNEY DISEASE | LIVER DISEASE | COPD/LUNG DISEASE | ADDICTION DISORDER | BLEEDING DISORDER | CANCER (PLEASE LIST TYPE) |
| MOTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| FATHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BROTHER(s) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SISTER(s) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL GRANDFATHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL GRANDMOTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL GRANDFATHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL GRANDMOTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| SOCIAL HISTORY |  |
| Diagnostic Tests/Procedures (Please list date of most recent) | SpecialistsName & Date Last Seen |
| Last Physical Exam |  | Colonoscopy |  | Heart/Cardio: |
| Last Lab Work |  | Endoscopy |  | Lung/Pulm: |
| Last Eye Exam |  | Other Colon Cancer Screen |  | Stomach/Gastro: |
| Last Dental Exam |  | Sleep Study |  | Kidney/Nephro: |
| EKG |  | Bone Density |  | OB/GYN: |
| Echocardiogram |  | Mammogram |  | Urology: |
| Chest X-ray |  | (Women Only) Last PAP |  | Ortho: |
| CT of Chest |  | (Men Only) Last PSA |  | Pain Med: |
|  | Psych: |
| Women Only | Neuro: |
| Age of Period Onset: |  | Regular? |  | Date last Period Began? |  | Hem/Oncology: |
| Pregnancies | Born Alive: | C-Section: | Premature: | Stillborn: |  | Other: |
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| Do you smoke tobacco? Yes / No | If yes, how many packs per day? | If yes, for how many years? |  |
| Do you smoke marijuana? Yes/No | Do you vape? Yes /No | Do you exercise daily? Yes/No | If yes, how many times a week? |
| Do you drink alcohol? Yes/No | If yes, how many per day? | If yes, how many times a week? |
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| Do you have any particular concerns to address today? If so, please list: |
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