



MEDICAL & FAMILY HISTORY FORM

NAME: _____

TODAY'S DATE: _____

DR. BEING SEEN _____

DATE OF BIRTH: _____

REFERRED BY: _____

REASON FOR VISIT _____

PRIMARY CARE PHYSICIAN: _____

Allergies:

- | | | | | | |
|----------------------------------|----------------------------------|--|--|---------------------------------|-------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Demerol | <input type="checkbox"/> IV Contrast or Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | Other _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Eggs | <input type="checkbox"/> Latex | <input type="checkbox"/> Propofol/Diprivan | <input type="checkbox"/> Versed | |

Past or Present Medical Problems:

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Gynecological Cancer | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Underactive Thyroid |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Psychiatric Disease | <input type="checkbox"/> Other Cancer _____ |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Reflux (GERD) | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizure Disorder | |
| <input type="checkbox"/> Celiac Sprue | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Sleep Apnea | |

Surgeries/Hospitalization/Procedures:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Prostate Surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Gastric Bypass/Obesity Surgery | <input type="checkbox"/> Hiatal Hernia Repair | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Gynecologic Surgery | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Upper Endoscopy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Defibrillator (AICD) | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> ERCP | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker | |

Social History - Marital Status

- Single
- Divorced
- Separated
- Widowed
- Married
- Partnered

Social History - Alcohol

- Never
- Rarely
- Daily
- More than 2 days/week.
- Less than 2 days/week.
- I quit using alcohol.

Social History - Occupation

Patient Occupation _____ Retired

Social History - Recreational Drugs

- I currently use recreational drugs.
- I have been treated for substance abuse.
- I have used IV drugs in the past.

Social History - Tobacco

- I use tobacco products.
- I quit using tobacco products.
- I have never used tobacco products.

Social History - Hobbies

Patient Hobbies _____

Review of Systems

Gastrointestinal

- None
- Abdominal pain
- Belching
- Black Stools
- Bloating
- Blood in Stool
- Change in Bowel Habits
- Constipation
- Diarrhea
- Gas
- Heartburn
- Hemorrhoids
- Incontinence to Stool
- Irritable Bowel Syndrome
- Jaundice
- Loss of Appetite
- Milk Intolerance
- Nausea
- Painful Bowel Movement
- Vomiting
- Other_____

Genitourinary

- None
- Blood in Urine
- Dark Urine
- Diminished Urine Flow
- Frequent Urinary Infections
- Frequent Urination
- Irregular Menstruation
- Pain on Urination
- Sexually Transmitted Disease
- Urinary Incontinence
- Other_____

Skin/Integument

- None
- Itching
- Rash
- Other_____

Cardiovascular

- None
- Angina/Chest Pressure w/activity
- Ankle Swelling
- Irregular Heart Beat
- Other_____

Neurological

- None
- Dizziness
- Headaches
- Seizures
- Stroke or Paralysis
- Other _____

Constitutional

- None
- Fever
- Night Sweats
- Weight Gain
- Weight Loss
- Other _____

Eyes

- None
- Change in Vision
- Dry Eyes
- Eye Pain
- Other _____

Ears, Nose and Throat

- None
- Bleeding Gums
- Chronic Sore Throat
- Dry Mouth
- Hoarseness
- Mouth Sores
- Nose Bleeds
- Other _____

Respiratory

- None
- Chronic Cough
- Shortness of Breath
- Wheezing
- Other _____

Endocrine

- None
- Cold Intolerance
- Excessive Thirst
- Other _____

Psychiatric

- None
- Abnormal Sleep
- Chronic Anxiety
- Depression
- Memory Loss/Confusion
- Other _____

Hematologic

- None
- Enlarged Glands
- Prolonged Bleeding
- Other _____

Musculoskeletal

- None
- Back Pain
- Joint Pain
- Muscle Pain
- Other _____

Immunologic

- None
- Ear Infections
- Flu
- Pneumonia
- Other _____

FAMILY HISTORY

	Father	Mother	Child(ren)	Brother(s)	Sister(s)	Other Relatives
Breast Cancer	0	0	0	0	0	0
Colon Cancer	0	0	0	0	0	0
Colon Polyps	0	0	0	0	0	0
Crohn's Disease	0	0	0	0	0	0
Diabetes	0	0	0	0	0	0
Esophageal Cancer	0	0	0	0	0	0
Gastric Cancer	0	0	0	0	0	0
Heart Disease	0	0	0	0	0	0
Liver Disease	0	0	0	0	0	0
Pancreatic Cancer	0	0	0	0	0	0
Ulcerative Colitis	0	0	0	0	0	0
Deceased	0	0				

YOUR PHARMACY

Name

Location

Phone Number

Fax Number

Medication Name

Dosages/Strength

How Often Taken?
