# Medical History

Patient Name: Visit Date:

**PAST MEDICAL HISTORY:**

Birth date:

Female



**FAMILY HISTORY:**  Adopted

Has anyone in your immediate family ever had any of the following disease? If so, please select the disease, person in your family and enter their age.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical condition:** | **Mother** | **Father** | **Brother** | **Sister** | **Maternal****Grandmother** | **Maternal****Grandfather** | **Paternal****Grandmother** | **Paternal****Grandfather** |
| Anxiety |  |  |  |  |  |  |  |  |
| ADD/ADHD |  |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |
| Alzheimer’s disease |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |
| Autoimmune disease |  |  |  |  |  |  |  |  |
| Blood pressure |  |  |  |  |  |  |  |  |
| Coronary artery disease |  |  |  |  |  |  |  |  |
| Cancer (specify below) |  |  |  |  |  |  |  |  |
| CVA (stroke) |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |
| Developmental delay |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Eczema |  |  |  |  |  |  |  |  |
| Hearing deficiency |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |
| High cholesterol |  |  |  |  |  |  |  |  |
| Irritable bowel disease |  |  |  |  |  |  |  |  |
| Learning disability |  |  |  |  |  |  |  |  |
| Mental illness |  |  |  |  |  |  |  |  |
| Migraines |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |
| Osteoarthritis |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |
| PVD |  |  |  |  |  |  |  |  |
| Renal (kidney) disease |  |  |  |  |  |  |  |  |
| Seizure disorder |  |  |  |  |  |  |  |  |

Other family history:

**SURGICAL HISTORY:** (list type and date):

**Tobacco use:**

# Medical History (cont.)

Have you ever used tobacco?  No/never  Yes Have you used tobacco in the last 30 days?  No  Yes Have you used smokeless tobacco in the last 30 days?  No  Yes

**Smoking Tobacco use:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Tobacco type:** | **Use daily:** | **Usage per day:** | **Years used:** | **Packs year:** | **Age started:** | **Age****stopped:** |
| **Cigarette** |  |  |  |  |  |  |
| **Cigarillo** |  |  |  |  |  |  |
| **Cigar** |  |  |  |  |  |  |
| **Pipe** |  |  |  |  |  |  |

**Non-Smoking Tobacco use:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Tobacco type:** | **Use daily:** | **Usage per day:** | **Years used:** | **Packs year:** | **Age started:** | **Age****stopped:** |
| **Chewing** |  |  |  |  |  |  |
| **Smokeless** |  |  |  |  |  |  |
| **Snuff** |  |  |  |  |  |  |

**Vaping:**

Have you ever vaped?  No/never  Yes

What is your current vaping status?  Current user  Not a current user

Device type:  Advanced Personal Vaporizers (APVs)  Disposable  E-Cigar  E-Cigarette  Rechargeable

 Other

Frequency:  Daily  Weekly  Occasionally  Other Current strength: % or \_mg.ML

Vaping reason:  Quit smoking  Socializing  Other

## Alcohol:

Do you drink alcohol?  No  Yes  Formerly Type of alcohol:  beer  liquor  wine

Frequency:  daily  weekly  monthly  yearly  occasionally  rarely  socially Amount: Last drink:  today  last night  yesterday  last week  two weeks ago  last month  last year

How many times in the past year have you had 5 or more drinks in a day?

## Drugs:

Any drug use?  No  Yes If yes, what kind of drug(s)? Any illegal drug use?  No  Yes Use of marijuana?  No  Yes

## Caffeine:

Do you drink/consume caffeine?  No  Yes Caffeine per day: Type of caffeine:  chocolate  coffee  energy drinks  soda  tablets  tea

## Lifestyle:

Changes in sleep patterns:  No  Yes Average number of hours of sleep per night: Trouble falling asleep:  No  Yes Difficulty staying asleep:  No  Yes

Frequent waking episodes at night:  No  Yes

Disrupted breathing, gasping, gagging, or choking for air during sleep:  No  Yes

Activity level:  moderate  sedentary  vigorous Health club member:  Now  Previously  Never

Type of exercise:

Exercise frequency:

Hours/week

Animals in the home:  No  Yes -  Birds  Dogs  Rodents  Cats  Reptiles  Other

 Do you clean up after the animals in your home?  No  Yes

Last FIT or Colonoscopy?  No  Yes

# of current sexual partners?

I use condoms:  Always  Sometimes  Never

## Menstrual/Pregnancy History:

How old were you when you had your 1st menstrual period? 1st day of last menstrual period?

Are your meses regular (every 21-35 days) or irregular?  Regular  Irregular How often do they come?

Is the flow:  Heavy  Normal  Light Do you have cramps?  No  Yes

Do you have bleeding between your menstrual periods?  No  Yes

Are you using a method to avoid pregnancy?  No  Yes. If so, what method do you use? Are you trying to achieve pregnancy?  No  Yes

How many times have you been pregnancy?

Any breast concerns like nipple discharge, lumps or pain?  No  Yes Do you do breast checks on yourself at home?  No  Yes

 Last Mammogram? Date: \_\_\_\_\_\_\_\_\_\_ Last Pap Smear? Date: \_\_\_\_\_\_\_\_\_\_\_\_

Last Colonoscopy? Date: \_\_\_\_\_\_\_\_

**Medication Reconciliation**

(Including vitamins, supplements and herbs)

|  |  |  |
| --- | --- | --- |
| **Name of Medication:** | **Dose:****(example: 100mcg, 10mg, etc.)** | **Frequency:****(example: once a day, before meals, etc.)** |
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|  |  |  |

Preferred pharmacy:

# Allergies

(Medical, seasonal, food)

|  |  |
| --- | --- |
| **Name:** | **Describe your reaction:** |
|  |  |
|  |  |
|  |  |