MEDICAL HISTORY INFORMATION FORM

Name :______________________________ Date:______________________________

Date of Birth : ____________________ SSN:______________________________

Primary Care Physician:____ Gender: M F

Pharmacy , And Location____

Pharmacy Telephone #:____________________

Current medications: Please write the name of all the drugs prescribed for you by any doctor including, the dosage and how many times you take the medication daily. If you need more space write them on the back of this sheet.

Medication Name	Strength	Times
Example: Amoxicillin	250 mg	4 times Daily

Allergies: Please write in the type of reaction that you have if you are allergic to any of the following, Please write any additional information about the allergies you have.

Allergy	Reaction	Allergy	Reaction	Allergy	Reaction
Drugs:		Tetracycline		Enviromental	
ACE Inhibators – Accupril/Monopril/ Captopril		Theopylline		Animal Dander	
Aspirin		NSAIDS – Advil Ibprofen, etc.		Dust	
Cephalosporins		Anti Fungal Creams		Mites	
Codeine		FOOD:		Molds	
Erythromycin		Chocolate		Pollen	
Iodine		Eggs		Adhesive Tape	
Penicillins		Milk		Latex	
Sulfa Drugs		Nuts		OTHER:	
		Shellfish			

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Immunizations: Please enter the month and the year that you last received any of the following Immunizations:

NAME	DATE	NAME	DATE	NAME	DATE
Flu		Measles		Phenumonia	
Hepatitis A		MMR Series		Tetanus/Td	
Hepatitis B		OPV Series		Tuberculiosis	
HepB Series		IPV Series		Varicella	

Family History: Enter the relationship under relative the age if deceased and any significant diseases or conditions known that relative under Medical Problems.

Relative	Alive? (y/n) If no, Age at death	Medical problems: Write in any conditions listed that apply to your family. Be sure to include other significant diseases or conditions known to your family member that may not be listed	
Example: Father	No, Age 87	Colon Cancer	Alcoholism
Father			Anemia
Mother			Arthritis
Brother			Asthma
			Bleeder
			Cancer Type/Location
Sister			Depression
			Diabetes/Sugar
			Epilepsy/Seizures
Son			Glaucoma
			Hay Fever
			Heart Disease
Daughter			High Blood Pressure
			Mental Illness
			Migrane/Headaches
Other			Osteoporosis/Brittle Bones
			Stroke
			Thyroid/Goiter

Medical History: enter the year that you were diagnosed with any of the conditions listed below. If not listed please write specifi diagnosis under other and the year you were diagnosed.

Condition	Year	Condition	Year	Condition	Year

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Anemia/Easy Bruising		Heart Murmur		Skin Condition	
Angina		Hepatitis or Jaundice		Stomach Ulcers	
Arthritis		Herpes		Stroke	
Athsma		Hiatal Hernia		Tuberculosis	
Bursitis		High Blood Pressure		Varicose Veins	
Cancer List type:		Hyperthyroidism		Whooping Cough	
Chicken Pox		Hypothyroidism		Other:	
COPD		Kidney Failure		Example:	
Depression (severe)		Kidney Infection		Migranes	
Diabetes		Kidney Stone			
Diverticulosis		Measles			
Epilepsy		Mental Illness			
Gall Bladder Disease		Mumps			
German Measles		Paralysis			
Gonorrhea		Phlebitis			
Gout		Rheumatic Fever			
Hay Fever		Scarlet Fever/ Scarletina			
Heart Attack		Seziures			
Heart Failure		Sexual Problems			

Surgical History: Please enter the year and the type of surgery that was done. If your surgical procedure is not listed below please write it in under other.

Description	Type	Year	Description	Type	Year
Example: Joint Replacement	Knee	1992	Hysterectomy – Abdominal		
Appendectomy			Hysterectomy – Ovaries		
Back Surgery			Tubal Ligation		
Blood Clots Removed			Joint Relacement		
Mastectomy			Pacemaker		
Lumpectomy			Prostate Surgery (TURP)		
Excision of a Cyst			Stomach Staples/Shrunk		
Breast Reduction			Thyroid		
Breast Implants			Tonsilectomy		
Cardiac Catheterization			Other:		
Cataract					
Colon Removed					
Coloctomy/Ileostomy					
Colonoscopy					
Gallbladder Removed					
Heart Mitral Valve Replacement					
Heart Aortic Valve					

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Replacement					
Angioplasty/Stent					
Coronary Artery Bypass					
Hemorroidectomy					
Hernia Repair					
Hysterectomy					

Social history :

Do you have a living will or advance directives? Y N

Have you given a copy of your living will or advance directives to your doctor? Y N

Alchohol Use:

How do you rate your intake of alcoholic Beverages? (Circle one of the following options)

Never Occasionally Moderate Heavy Previous Use Year Quit: ______________

Do you consider your intake of alcoholic beverages to be a problem? If so, would you like to quit? Y N

Have you ever tried to quit? Y N

Tobacco Use:

How do you rate your use of tobacco? (Circle one of the following options)

Non Smoker Cigarettes Smoke a Pipe Smoke Cigars Chew Tobacco Use Snuff

Previous Smoker: # of years smoked _____ What year did you quit _____ Packs Per day____

If you use tobacco would you like to quit? Y N

Have you ever tried to quit? Y N

Do you, or have you ever, taken drugs other than over the counter medications that were not prescribed to you? Y N

If yes, Please Describe :

____

____

Caffeine Intake :

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How do you rate your intake of caffeine from any source – coffee, tea, soda- Each day? (circle one of the following options)

None 1-3 cups/glasses/cans 4-6 cups/glasses/cans More than 6 Cups/Glasses/Cans

Sexual Activity:

How would you describe your history of sexual activity? (Circle one of the following)

Have never been sexually active Currently sexually active Not Currently sexually active

If you use Birth control which method do you use: (circle one of the following)

Condom Foam/Jelly Implants Sponge Depro – Provera Shot
Diaphragm Pill Rhythm Vasectomy Tubal Ligation Hysterectomy

Risk for Sexually Transmitted Diseases:

Do you feel you are at risk for sexual transmitted sexual diseases? Y N

Exercise History:

Please describe your exercise activity level : (circle one of the following)

Inactive Light Moderate Heavy Vigorous

Living Conditions:

Live Alone With Parents With relatives With roomates With spouse With caregiver
With domestic Partner In group Home Assisted living Facility Nursing Home Recive Hospice Care Live with someone with TB

Seat Belt/Helmet Use:

Do you wear a seat belt?

Always Almost Always Occasionally Never Not Applicable

Do you wear a helmet when you ride a bike, skate, or use a scooter?

Always Almost Always Occasionally Never Not Applicable

Gynecological/Pregnancy/Birth History

Do you have menstrual periods? Y N

If no, what year did you stop? ______

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How many times have you been pregnant? ______

How many times did pregnancy result in live birth? ______

How many times did pregnancy result in one of the following?

Still Born___ Miscarriage_____ Abortion_____