Waugh Chapel Family Medicine

Medical History Form

Name: _____ DOB: _____

Past Medical History: Have you ever had or currently have any of the following? (Please Circle)

High Blood Pressure	Yes	No	High Cholesterol	Yes	No
Diabetes	Yes	No	Cancer: (type)_____	Yes	No
Heart Disease	Yes	No	Stroke	Yes	No
Thyroid Disease	Yes	No	Allergies/Hay Fever	Yes	No
Depression	Yes	No	Anxiety	Yes	No
Bladder Infections	Yes	No	Kidney Infections	Yes	No
Kidney Stones	Yes	No	Bowel Problems	Yes	No
Asthma	Yes	No	Tuberculosis	Yes	No
Pneumonia	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Skin Problems/Rash	Yes	No
Breast Problems	Yes	No	Venereal Disease/STD	Yes	No
Chicken Pox	Yes	No	Measles	Yes	No
Hernia	Yes	No	Head Injury/Concussion	Yes	No
Seizures	Yes	No	Substance Abuse	Yes	No

For Women: Last Menstrual Period _____

Operations/Surgeries:

_____

_____

Hospitalizations:

_____

_____

Medications (Please list present medications and dosages, including herbals, vitamins, and over the counter meds)

Medication Dose How often do you take it?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies:

_____
_____

Other Allergies:

_____
_____

Preventative Medicine:

Last colonoscopy? _____

Last pap smear? _____

Last mammogram? _____

Last prostate screen? _____

Last Tetanus shot? _____

Last Pneumonia shot? _____

Last Flu shot? _____

Last Shingles shot? _____

Last Dilated Eye Exam? _____

Social History:

Do you smoke?	Yes	No	Cigarettes__ Cigars___ Pipes ____ How many per day? _____
Have you ever smoked?	Yes	No	If so, for how long? _____
			When did you quit? _____
Use smokeless tobacco?	Yes	No	If so, how much? _____
Do you drink alcohol?	Yes	No	How often? Seldom____ Regularly____ Occasionally Excessive_____
Do you use street drugs?	Yes	No	How often? Seldom____ Regularly____ Occasionally Excessive_____
Have you ever used drugs?	Yes	No	If so, for how long? _____
			When did you quit? _____
Exercise regularly?	Yes	No	
Regularly use sunscreen?	Yes	No	
Are you sexually active?	Yes	No	Heterosexual____ Homosexual _____ Bisexual (both) _____

Potential Areas of Stress:

Where do you work?_____ Occupation?_____

Who lives in your household?_____

Any marital problems?_____

Does anyone living with you have drug or alcohol problems?_____

What are you biggest life stressors at this time?

_____

_____

What do you do for recreation and relaxation?

_____

_____

Family History: Any blood relative with following conditions, please check box.

	Mother	Father	Other (please indicate relation)
ADD	□	□	_____
Alcoholism/Substance Abuse	□	□	_____
Arthritis	□	□	_____
Asthma	□	□	_____
Breast Cancer	□	□	_____
Cancer	□	□	_____
Depression	□	□	_____
Dementia	□	□	_____
Diabetes	□	□	_____
Epilepsy/Seizures	□	□	_____
High Blood Pressure	□	□	_____
High Cholesterol	□	□	_____
Heart Disease/Heart Attacks	□	□	_____
Kidney Problems	□	□	_____
Stroke	□	□	_____
Stomach Problems	□	□	_____
Thyroid Disease	□	□	_____

Please describe briefly your current medical problems and the reason for your visit:

_____
_____
_____
_____
_____
_____
_____
_____