MEDICAL HISTORY AND SCREENING FORM

Name: ________________________________ **Birth date:** ____________ **Date:** _______________

May I send a copy of your consultation to your other physicians or primary health care provider and consult with them as necessary? ☐ Yes ☐ No Signature: ____

Marital Status: ______________________ **Sex:** ☐ Male ☐ Female **Occupation:** ____________________________

Present Medical History

Comments: ____

Date: last Colonoscopy: _____________ ☐ Normal. Date: last Eye exam: ______________ ☐ Normal.

Date: last Physical Exam: ___________ ☐ Normal. Date: last Chest X-ray:____________ ☐ Normal.

Date: last Dental visit: ______________ ☐ Normal. Date: last (EKG or ECG): __________ ☐ Normal.

List any Prescription medications & dietary supplements or vitamins you are now taking:

1. Medication: ______________________Dose:________How many times per day?_____________
2. Medication: ______________________Dose:________How many times per day?_____________
3. Medication: ______________________Dose:________How many times per day?_____________
4. Medication: ______________________Dose:________How many times per day?_____________
5. Medication: ______________________Dose:________How many times per day?_____________
6. Medication: ______________________Dose:________How many times per day?_____________
7. Medication: ______________________Dose:________How many times per day?_____________
8. Medication: ______________________Dose:________How many times per day?_____________

List any drug allergies:

Medication: ____________Reaction: ____________Medication: __________Reaction: ____________

Medication: ____________Reaction: ____________Medication: __________Reaction: ____________

Medication: ____________Reaction: ____________Medication: __________Reaction: ____________

List Hospitalizations or Surgeries:

____

____

____

Dates and reasons for Hospitalization or Surgeries:

____

____

____

Immunization History

Hepatitis B Vaccine ☐ Yes______ ☐ No

Pneumococcal Vaccine ☐ Yes______ ☐ No

Influenza B Vaccine ☐Yes______ ☐ No

Tetanus Booster ☐Yes______ ☐ No

Zoster Vaccine ☐Yes______ ☐No

Tuberculosis Vaccine ☐Yes______ ☐ No

Chronic Diagnosed Past Medical History

Check and/ or circle those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, When? __________
- ☐ Arthritis Where? _________ What type? _______
- ☐ Heart murmur or Cardiovascular Disease
- ☐ Inflammatory Bowel Disease
- ☐ Kidney disease What type? __________
- ☐ Diabetes Type I or Type II -Last HgA1C?_________
- ☐ STD What type? ___________
- ☐ HIV
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Cancer What type? _________
- ☐ Hypertension
- ☐ Ulcer What type? _________
- ☐ Organ Transplant What type? ___________
- ☐ Glaucoma or Cataracts
- ☐ Anemia
- ☐ Thyroid problems What type? __________
- ☐ Pneumonia
- ☐ Sickle cell
- ☐ Scoliosis
- ☐ Asthma or COPD
- ☐ Lupus
- ☐ Migraines
- ☐ Substance Abuse Disorder What type? ________
- ☐ Lung disease
- ☐ COPD
- ☐ Hyperlipidemia
- ☐ Psoriasis
- ☐ Liver disease or Hepatitis C
- ☐ Mental Health Conditions Circle one:
  (Schizophrenia, Bipolar, PTSD, Anxiety, Depression, ADD, Autism)
- ☐ Other: _______________________
- ☐ Other: ______________________

Family Medical History

Father: ☐Alive Current age _____ Medical Problems: ________________________ ☐ Deceased ☐ Age at death ______

Mother: ☐Alive Current age _____ Medical Problems: ________________________ ☐ Deceased ☐ Age at death ______

Have your **blood relatives** had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)? **Check** those to which the answer is yes and **who**? (Leave other blank):

- ☐ Heart attack _______________
- ☐ Strokes__________________
- ☐ High blood pressure ________
- ☐ Elevated cholesterol________
- ☐ Diabetes_________________
- ☐ Asthma or COPD__________
- ☐ Heart disease______________
- ☐ HIV_____________________
- ☐ Anemia__________________
- ☐ Glaucoma________________
- ☐ Mental Health_____________
- ☐ Anemia__________________
- ☐ Sickle cell________________
- ☐ Leukemia_________________
- ☐ Cancer___________________
- ☐ Other:___________________

Social History: Organ donor? ☐Yes ☐No Religious Beliefs: ____________ Alcohol Use ☐Yes ☐No ☐ Occasional

Smoking ☐Yes ☐No How many per day? ______ Starting Age_______ Quitted Smoking? ☐Yes When? ____________

OB-GYN Health: Last Menstrual Period ________ Birth Control Method _______________ Sexually Active__________

Date: last Pap smear___________ Hx of Abnormal Pap smear_______________ Date: last Mammogram _______________

Pregnancy History:

Total Number ____________ Abortions _____________ Tubal Pregnancies ____________

Miscarriages ____________ Premature _____________ Living children ____________

Men's Health: Date: last **P**rostate-**S**pecific **A**ntigen levels____________ Date: last Rectal Exam-Prostate____________

Sexually Active _____________ What kind of protection/method do you or your partner us? __________________________