advocare | Family Medicine Associates

MEDICAL HISTORY

DATE _____ / _____ / _____

Name _____ Age _____ Birthdate _____ / _____ / _____

Address _____ Sex: M ☐ F ☐

_____ Home Phone _____

_____ Work Phone _____

Occupation _____ Emergency Contact Phone _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

If Married, Spouse's Name _____

Children's Names and Ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances

No ☐ **Yes** ☐

(If yes, please list name of medicine and type of reaction):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History & Review of Systems

Please circle if **you** have had problems with or are presently experiencing any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain/Chest Tightness
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay Fever
18. Abdominal Discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in Stool
25. Ulcers
26. Change in Bowel Habits
27. Unexplained Weight Gain/Loss
28. Hemorrhoids
29. Gall Bladder Disease
30. Colitis
31. Hepatitis or Jaundice
32. Thyroid Disease
33. Head or Neck Radiation
34. Headache
35. Kidney Diseases
36. Kidney Stones
37. Difficulty Urinating
38. Arthritis
39. Low Back Problems
40. Skin Diseases
41. Blood Disorders
42. Venereal Diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol Abuse
47. Drug Abuse
48. Gout
49. _____
50. _____

_____

_____

_____

_____

_____

_____

_____

_____

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: No ☐ Yes ☐ (Please describe): _____

Leakage of urine: No ☐ Yes ☐ (Please describe): _____

Pelvic pain: No ☐ Yes ☐ (Please describe): _____

Abnormal discharge: No ☐ Yes ☐ (Please describe): _____

History of abnormal PAP smear: No ☐ Yes ☐ (Type of treatment): _____

This information is for use by your physician as part of your confidential medical record.

Please continue to next page

Patient Name: ***Date:*** / /

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization History – Have you had: pneumovax immunization? No ☐ Yes ☐ When?: _____

Hepatitis B? No ☐ Yes ☐ When?: _____ flu immunization? No ☐ Yes ☐ When?: _____

Other_____ ? No ☐ Yes ☐ When?: _____ tetanus immunization? No ☐ Yes ☐ When?: _____

When was your last:

pap smear?_____ breast exam?_____ stool check for blood? _____

mammogram?_____ cholesterol check?_____ prostate exam? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which Family/Members?	Approx. Age When Diagnosed
Cancer (describe type)		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (anxiety, depression, etc.)		
Drug or Alcohol Addition		
Glaucoma		
Bleeding Diseases		
Other: _____		

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts? No ☐ Yes ☐ If no, why not?_____

Do you wear a bike helmet? No ☐ Yes ☐ N/A ☐

Do you exercise regularly? No ☐ Yes ☐ If yes, type, duration and number of times per week? _____

Do you smoke? No ☐ Yes ☐ If yes, how many packs per day?_____

Do you drink alcoholic beverages? No ☐ Yes ☐ If yes, how much per week? _____

Do you drink coffee No ☐ Yes ☐ If yes, how many cups per day? _____

Do you drink tea No ☐ Yes ☐ If yes, how many cups per day? _____

If there is a gun in your home do you keep it unloaded and out of children's reach? No ☐ Yes ☐ N/A ☐

Do you use drugs? (marijuana, cocaine, crack, etc.) No ☐ Yes ☐ If yes, explain:_____

Have you ever engaged in any activity which has put you at risk of getting AIDS? No ☐ Yes ☐ If yes, explain:_____

Do you wish to be tested for AIDS? No ☐ Yes ☐

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? No ☐ Yes ☐ If yes, explain: _____

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? No ☐ Yes ☐

Do you ever feel afraid of your partner? No ☐ Yes ☐ N/A ☐

Do you have a "living will"? No ☐ Yes ☐

Do you have a donor card? No ☐ Yes ☐

Method of birth control: _____

This information is for use by your physician as part of your confidential medical record.