# MedStar Medical Group

MMG at Dorsey Hall
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## Medical History

Date: / /

Name:_____ Age:_____ D/O/B:_____/_____/_____

Occupation:_____ Sex: _____M _____F

Marital Status: _____Single _____Married _____Divorced _____Widowed _____Separated

If married, spouse's name:_____

Children's names and ages:_____

Who else lives in your household?_____

Where were you born & raised?_____ Highest level of education?_____

**Allergies** to medications, x-ray dyes, or other substances _____ NO _____ YES

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

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

### Past Medical History and Review of Systems

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

| | | | |
|---|---|---|---|
| High Blood Pressure | Bronchitis | Change in bowel habits | Arthritis |
| Diabetes | Pneumonia | Unexpected weight gain/loss | Low Back Problems |
| Cancer | Persistent Cough | Hemorrhoids | Skin Diseases |
| Heart Disease | TB | Blood Disorders | Chest Pain/Chest Tightness |
| Abdominal Discomfort | Colitis | Anxiety | Depression |
| Shortness of Breath | Indigestion | Hepatitis or Jaundice | Swollen Ankles |
| Nausea | Thyroid Disease | Anemia | Palpitations |
| Vomiting | Alcohol Abuse | Head or Neck Radiation | Lightheadedness |
| Constipation | Headache | Drug Abuse | Frequent Urination |
| Diarrhea | Kidney Disease | Gout | Rheumatic Fever |
| Blood in Stool | Kidney Stones | Sexual Dysfunction | Asthma |
| Ulcers | Cholesterol | Difficulty Urinating | |

_____

_____

_____

## Gynecologic and Obstetric History

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

Pregnancies:_____ Births:_____ Miscarriages:_____

Prolonged or Abnormal Bleeding _____ NO _____ YES Describe_____

Leakage of Urine _____ NO _____ YES Describe_____

Pelvic Pain _____ NO _____ YES Describe_____

Abnormal Discharge _____ NO _____ YES Describe_____

History of Abnormal Pap Smear _____ NO _____ YES Describe_____

## Please List and Supply the Date of:

Operations:_____

_____

Hospitalizations other than for Surgery:_____

_____

_____

**Immunization History-Have you had:**

Pneumovax _____ NO _____ YES When_____

Hepatitis B _____ NO _____ YES When_____

Flu Vaccine _____ NO _____ YES When_____

Tetanus _____ NO _____ YES When_____

Other _____ 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 Member(s) | Approximate Age When Diagnosed |
|---|---|---|
| Cancer (describe what type) | _____ | _____ |
| Hypertension (High Blood Pressure) | _____ | _____ |
| Heart Disease | _____ | _____ |
| Diabetes | _____ | _____ |
| Stroke | _____ | _____ |
| Mental Disease (Anxiety, Depression) | _____ | _____ |
| Drug or Alcohol Addiction | _____ | _____ |
| Glaucoma | _____ | _____ |
| Bleeding Disorders | _____ | _____ |
| Hip Fracture | _____ | _____ |
| Other | _____ | _____ |

## Medications (Prescription, Over-the-counter, Vitamins, Herbs, Etc.)

| Drug | Dose | **Preferred Pharmacy:** |
|---|---|---|
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |