

## MEDICAL/SOCIAL HISTORY FORM

PLEASE complete this form to the best of your knowledge. For first health assessment, fill out both sides.

Name	Date of Birth / /	Place of Birth	Occupation	Primary Care Physician
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Date of Visit	Highest Level of School	Religious Preference (not required)	Organ Donor?	Who Referred You?
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Medical History: List serious illnesses, injuries, operations, and other hospitalizations and indicate year these occurred.

PROBLEM	YEAR	PROBLEM	YEAR

LIST MEDICINES YOU TAKE NOW (INCLUDING VITAMINS, BIRTH CONTROL PILLS, OVER-THE-COUNTER DRUGS)

MEDICINE AND DOSE (IF KNOWN)	MEDICINE AND DOSE (IF KNOWN)

	YES	NO		YES	NO
HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICINE? WHICH? _____ DESCRIBE REACTION: _____			DO YOU KNOW OF ANY CONDITION FOR WHICH YOU BELIEVE YOU NOW NEED OR WILL NEED TREATMENT? (MEDICINE, SURGERY OR PREGNANCY, ETC.) IF YES, WHAT? _____		
HAVE YOU EVER HAD A PNEUMONIA VACCINE?			HAVE YOU BEEN UNDER A PHYSICIAN'S CARE FOR A CHRONIC CONDITION? IF YES, WHY? _____		
HAVE YOU HAD AN ALLERGIC REACTION TO INSECT BITES OR STINGS? DESCRIBE: _____			HAVE YOU BEEN REJECTED FOR INSURANCE, MILITARY SERVICE OR EMPLOYMENT FOR A MEDICAL REASON? IF YES, WHY? _____		
DO YOU HAVE OTHER ALLERGIES: DESCRIBE: _____			HAVE YOU EVER HAD AN EYE EXAM? IF YES, WHEN WAS THE MOST RECENT? _____		
DO YOU SMOKE? IF SO, HOW MANY PACKS PER DAY? _____ DID YOU EVER SMOKE? IF SO, HOW MANY PACKS PER DAY? _____ YRS? _____			HAVE YOU EVER BEEN EXPOSED TO HAZARDS AT YOUR JOB? WHAT HAZARD? _____		
DO YOU DRINK ALCOHOL? (INCLUDING BEER) APPROXIMATE QUANTITY PER WEEK? _____ IS THIS A PROBLEM FOR YOU OR YOUR EMPLOYER?			DO YOU USE SEATBELTS REGULARLY?		
DO YOU USE ANY STREET DRUGS? WHAT? _____ HOW OFTEN? _____			DO YOU PRACTICE SAFE SEX? (MONOGAMOUS RELATIONSHIP / CONDOMS / CELIBATE)		
HAS A PSYCHIATRIST EVER TREATED YOU? IF YES, WHEN? _____  DID YOU RECEIVE IN-PATIENT TREATMENT? IF YES, WHEN? _____			DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES?  IF NOT, ARE YOU INTERESTED IN MORE INFORMATION?		
<u>LEARNING NEEDS ASSESSMENT</u> ARE THERE ANY PERSONAL RELIGIOUS AND/OR CULTURAL ASPECTS WE NEED TO CONSIDER IN REGARDS TO LEARNING/TEACHING? IF SO, WHAT ARE THEY?			WHO LIVES WITH YOU?		
			DO YOU FEEL SAFE AT HOME?		
WHAT IS THE EASIEST WAY FOR YOU TO LEARN?  o READING   o LISTENING   o DEMONSTRATION			HAVE YOU HAD CHICKEN POX AS A CHILD?		
DO YOU HAVE A PHYSICAL DISABILITY? IS YES, DESCRIBE.			DID YOU HAVE YOUR ANNUAL MEDICAL PHYSICAL DONE? DATE:		

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

# FAMILY MEDICINE/INTERNAL MEDICINE

## REVIEW OF SYSTEMS

FAMILY HISTORY: PLEASE CHECK BOX AND CIRCLE RELATIONSHIP TO YOU.

PGF: Paternal Grandfather PGM: Paternal Grandmother M: Mother F: Father  
 MGF: Maternal Grandfather MGM: Maternal Grandmother B: Brother S: Sister

	PGF	PGM	MGF	MGM	M	F	B	S
Arthritis								
Asthma/COPD								
Cancer (type) _____								
Coronary Artery Disease								
Depression/Anxiety								
Diabetes								
GI Disorders								
High Cholesterol								
Hypertension								
Migraines								
Obesity								
Stroke								
Other: _____								

STATEMENT OF PRESENT HEALTH: (GIVE A DESCRIPTION OF PAST HISTORY, IF COMPLAINT EXISTS):

DO YOU FOLLOW A PARTICULAR DIET? PLEASE CIRCLE ALL THAT APPLY

· DIABETIC      · LOW CALORIE      · LOW CARB      · LOW FAT      · VEGETRAIN/VEGAN      · OTHER \_\_\_\_\_

DO YOU PARTICIPATE IN REGULAR EXERCISE? YES/NO      FREQUENCY: \_\_\_\_\_

WHAT TYPE? \_\_\_\_\_

HAVE YOU TRAVELED OUTSIDE THE UNITED STATES WITHIN THE PAST 5 YEARS? YES/NO

WHERE: \_\_\_\_\_

WHEN: \_\_\_\_\_

FEMALES ONLY:

WHEN WAS YOUR LAST MENSTRUAL PERIOD? \_\_\_\_\_

NUMBER OF PREGNACIES? \_\_\_\_\_      NUBMER OF BIRTHS? \_\_\_\_\_

ARE YOU CURRENTLY ON ANY BIRTH CONTROL? YES/NO      IF YES, PLEASE INDICATE: \_\_\_\_\_

WOULD YOU LIKE A PHYSICIAN TO DISCUSS FAMILY PLANNING WITH YOU? YES/NO

IMMUNIZATIONS:

INFLUENZA: YES/NO      DATE: \_\_\_\_\_

PNEUMOVAX: YES/NO      DATE: \_\_\_\_\_

TETANUS: YES/NO      DATE: \_\_\_\_\_

ZOSTAVAX (SHINGLES): YES/NO      DATE: \_\_\_\_\_

OTHER: \_\_\_\_\_      DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

SYSTEM REVIEW: PLEASE CHECK THE APPROPRIATE BOX: FOR EACH PROBLEM CHECK NEVER, PAST OR NOW.

<p>N E P V A N E S O R T W</p> <p>HAVE YOU EVER HAD:</p> <p>o o o GENERAL/CONSTITUTIONAL: Unexplained weight loss or weight gain o o o Excessive fatigue o o o Difficulty performing daily activities such as: <i>bathing, cooking, cleaning.</i> o o o Prolonged fever/chills o o o Other:</p> <p>o o o HEAD/EYES/EARS/NOSE/THROAT o o o Frequent or severe headaches o o o Wear glasses or contact lenses o o o Chronic nasal discharge, drainage or sneezing o o o Impaired hearing o o o Other:</p> <p>o o o NEUROLOGICAL: o o o Memory loss o o o Fainting, dizziness, seizures, convulsions o o o Other:</p> <p>o o o CARDIOVASCULAR o o o Rheumatic Fever o o o Pain or pressure in chest o o o Any heart trouble o o o Palpitation or pounding beat o o o Abnormal heart rhythm or murmur o o o Swelling of ankles o o o High blood pressure o o o Other:</p> <p>o o o RESPIRATORY o o o Chronic cough o o o Asthma or wheezing o o o Shortness of breath at night o o o Shortness of breath anytime o o o Other:</p> <p>o o o GASTROINTESTINAL o o o Abdominal pain o o o Loss of appetite o o o Change in bowel habits (constipation or diarrhea) o o o Blood in stool o o o Hemorrhoids or rectal disease o o o Nausea/vomiting o o o Other:</p> <p>o o o GENITOURINARY o o o Frequent urination at night o o o Frequent or painful urination o o o Difficulty holding urine o o o Difficulty stopping or starting urine stream o o o Urinary tract infection</p> <p>o o o MALE o o o Sores or discharge from penis o o o Lump or pain of testicle o o o Sexually transmitted disease o o o Condom use o o o Problems with sexual function</p>	<p>N E P V A N E S O R T W</p> <p>HAVE YOU EVER HAD:</p> <p>o o o FEMALE o o o Method of birth control if sexually active/heterosexual o o o Mid-cycle bleeding o o o Pain with intercourse o o o Vaginal discharge or sores o o o Painful periods o o o Sexually transmitted disease o o o Problem with sexual function o o o Periods regular o o o Pregnant</p> <p>o o o MUSCULOSKELETAL o o o Pain in joints/arthritis o o o Chronic back pain or injury o o o Other:</p> <p>o o o SKIN/BREAST o o o Change or new growth in mole o o o Breast lump o o o Breast nipple discharge o o o Other:</p> <p>o o o EMOTIONAL o o o Trouble sleeping o o o Depression o o o Anxiety or nervousness o o o Loss of memory o o o Other:</p> <p>o o o HEMATOLOGIC/LYMPH o o o Anemia o o o Excessive bleeding or abnormal bruising o o o A transfusion o o o Any swelling of lymph nodes o o o Other:</p> <p>o o o ENDOCRINE o o o Cold or heat intolerance, any thyroid problems o o o Excessive thirst or hunger o o o Other:</p> <p>o o o OPTIONAL o o o Are you sexually active o o o Are you sexually active with members of opposite sex o, same sex o, or both o o o o If sexually active with the opposite sex, do either of you use contraception (birth control?) If yes, what form?</p> <p>REVIEWED BY PHYSICIAN</p> <p>_____ DATE _____</p>
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NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_