PRIMARY CARE & MEDICAL NUTRITION CENTER

MEDICAL HISTORY FORM

Name: _____ Age: _____

Date: _____Date of Last Physical: _____ DOB: _____

Please fill in the following:

1. Reason for visit/current health problems: _____
   _____
   _____
2. Significant health problems in the past: _____
   _____
3. Surgeries: _____
   _____
4. Hospitalizations for non-surgical problems: _____
5. Medications (prescription, non-prescription, vitamins, herbal and supplements):

Name	Strength	Dose per day

6. Allergies or serious reactions to any medications or substances (e.g. food, latex contact, etc):_____
   _____

7. Family history:

	Chronic medical illness
Father	
Mother	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
MaternalGrandmother	
Siblings	

8. Do you smoke cigarettes, pipes, or cigar? How much? _____
9. Do you drink alcohol? How many drinks per week? (One drink is equal to 2oz. of hard liquor, 4 oz. of wine, or 12oz. of beer) _____
10. Do you use any recreational drugs (e.g. Marijuana, cocaine, etc)? _____
    _____
11. Have you ever used recreational drugs intravenously? _____
12. What type of work do you do? _____
13. Are you exposed to any dangerous substances at work? (e.g. asbestos, chemical solvents, etc)?
    _____
14. What is your marital status? _____
15. How many children do you have? _____
16. Do you wear seatbelts when driving or as a passenger in a car? _____
17. Do you see any other doctors regularly? _____
18. Do you have a living will? _____
19. Do you get any regular exercise (e.g. walk, jog, or bicycle)? For how long each time and how many days a week?
    _____
    _____
20. What is your diet? ☐ Regular _____ ☐ Vegetarian _____ ☐ Vegan _____
21. What is your stress level? _____
22. What is your daily caffeine intake? _____

REVIEW OF SYMPTOMS
(Please circle any symptom that is recent and bothersome and answer the questions below)

GENERAL
Fatigue; Generalized Weakness; Poor sleep; Snoring; Unintentional weight loss; Fever; Swollen glands

HEART
Chest pain/discomfort at rest; Chest pain/discomfort with exertion; Palpitations or abnormal sensation of the heart beating; Pain in the legs with walking; Swelling of the ankles and feet

LUNGS
Difficulty breathing at rest; Difficulty breathing with exercise; Cough; Wheezing

STOMACH
Pain in the abdomen; Loss of appetite; Heartburn; Indigestion; Nausea; Vomiting; Throwing up blood; Diarrhea; Constipation; Blood in the stool; Black stools; Hemorrhoids

THROAT, SINUS, EAR
Ear pain or pressure; Deafness; Sinus pain/pressure; Diminished sense of smell; Sore throat; Swallowing that is difficult or painful; Sneezing

EYES
Poor vision; Painful eyes; Discharge from eyes; Cataracts;

SKIN
Rash/itch; Sores/Lumps; Easy bruising/bleeding; Change in mole

URINARY
Frequent Urination; Painful urination; Bloody or abnormal colored urine; Unintentional leakage of urine

SEXUAL
Heterosexual, Homosexual, or Bisexual; Multiple sexual partners; Diminished or absent sexual drive
Men only: Difficulty getting or maintaining erections; Lumps or pain in the testicles; Discharge from the penis;
Women only: Abnormal vaginal dryness; Painful sexual intercourse; Vaginal discharge;
Type of birth control used: _____

GYNECOLOGICAL (Women only)
Abnormal vaginal discharge; Irregular menstrual cycles; Hot flashes or other menopausal symptoms
Last menstrual cycle: _____

BREAST (Women only)
Lump; Pain; Milky nipple discharge; Bloody nipple discharge

SKELETAL
Joint pain; Swollen joints; Back pain; Back pain; Previous fractures; Difficulty walking; Orthotics/assistive devices

NEUROLOGIC
Headache; Dizziness/fainting; Weakness/paralysis; Dizziness/fainting; Decreased sensations; Tremors; Problem with coordination; Speech/communication problem; Change in memory

HEMATOLOGICAL
Anemia; Blood transfusions; Blood clots

EMOTIONAL
Feelings of depression/hopelessness/helplessness; Feelings of anxiety; Suicidal thoughts
Have you ever been physically or emotionally abused by someone close to you? _____
_____
Name of Psychiatrist: _____
Psychiatric Diagnosis: _____

PREVENTIVE CARE:

1) Date of last mammogram (women only): _____Result: _____
2) Date of last PAP (women only): _____Result: _____
3) Date of last DEXA scan (women only): _____Result: _____
4) Date of last screening colonoscopy (men & women): _____Result: _____
5) Vaccine dates: Tetanus: _____Flu: _____Pneumonia: _____
   Hepatitis: _____

Signature: _____ Date: _____