Primary Care Pediatrics and Family Medicine

Medical History:

Patient:________________________________

DOB:____/____/_____

Please list the names and telephone numbers of the other physicians involved in your care:

Name	Specialty	Phone	Address	Receive Report (Y/N)

List the names of prescription Medications you are currently taking:

Name of the Medication	Dose	Frequency	Side effects, if any

List the names of Nonprescription medications or supplement you are currently taking:

Name of the Medication	Dose	Frequency	Side effects, If any

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Have you ever had any allergies or reaction to any medications or supplements? Yes / No

Name of medication/Supplement	Allergies/Reaction

Past medical History: Please check if you have or have had:

☐ Arthritis
☐ Diabetes Mellitus
☐ High BP
☐ Kidney Disease/Stones
☐ STD
☐ Cancer (Type/Treatment)
☐ Asthma
☐ Emphysema
☐ High Cholesterol
☐ Migraines
☐ Stroke
☐ Bleeding Difficulties
☐ Heart Disease
☐ HIV
☐ Osteoporosis
☐ TB
☐ Depression
☐ Hepatitis
☐ Insomnia
☐ Seizure Disorder
☐ Thyroid Disease

Other:____

____

Past Surgical History:

Surgery	Date

Social History:

Occupation: ________________________Marital Status: _________Number of Children: _________________
Hobbies/Recreation _________________Exercise: Yes/No Type of Exercise :__________________________

Frequency: #hours per days per week ____

Tobacco / Alcohol / Beverages:

Tobacco: Never smoked _____

Past Smoker: Cigarettes- Quit Date ________ # packs/day ____   Cigars- Quit Date ______ # packs/day___
Current Smoker: ____ Every day Smoker ____ Intermittent Smoker # cigarettes/cigars per day _________
Smokeless Tobacco: ____ Current Number cans/pouches per day ___________

Alcohol: None _____

Frequency: ____ Rare ____ Social ____ Regular Use ____ Binges

Quantity: # drinks per day ______ # drinks per week ______ # drinks per month ______

Types of alcohol: ____

Previous attempt to quit? ____________________

Caffeine: Coffee_____ Tea _________ Soda ________ None ____

servings per day ____

Illicit Drug Use: Current Use: ____ No ____ Yes

Type: ____

Prior Use: ____ No ____ Yes

Type: ____Quit Date:____________

Family History:

Illness	Father	Mother	Brother	Sister	Maternal G. Mother	Maternal G. Father	Paternal G. Mother	Paternal G. Father
Hypertension								
Hyperlipidemia								
Diabetes								
Stroke								
Depression /Mental disease								
Heart disease								
Thyroid disease								
osteoporosis								
Alcoholism								
Glaucoma								
Cancer								
Bleeding disorder								

Father: Living / Deceased Age ____ Cause of Death _______________________________________

Mother: Living / Deceased Age ____ Cause of Death _______________________________________

Brothers: # Alive ____

Deceased____ Age____ Cause of Death _______________________________________

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Sisters: # Alive ____

Deceased______ Age____ Cause of Death _______________________________________

Health Maintenance:

	Last time (date)	Any abnormality
Cholesterol Check		
Mammogram		
Colonoscopy		
Bone density		
Eye Exam		
Hearing test		
EKG/Stress test		

Immunization:

Vaccination	Date
Hepatitis A	
Hepatitis B	
Influenza	
Pneumonia (Pneumovax / Prevnar 13)	
Shingles	
Tetanus	

Do you have a living Will? Yes / NO

Gynecologic / Obstetric History: Females Only

Times Pregnant ________

Problems with pregnancy? ____

Problems with menstrual cycles: _____ None ______ Irregular

frequency/duration ______ Dysmenorrhea ______ Heavy Bleeding ______ Other

Current birth control: ____________

Age at onset of periods: ______________________

Age at onset of menopause: _______________________

Pap Smears: Never ______ Date of last pap _______________History of abnormal pap smear? ☐ No ☐ Yes

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Review of System: Circle, if any

General	Eyes	ENT	Cardiovascular	Respiratory	Gastrointestinal	Genitourinary
Fatigue	Blurry vision	Sore throat	Chest pain	cough	Nausea	Blood in urine
Fever	Double vision	Nose bleeding	Dizziness	Shortness of breath	Vomiting	Burning urination
Night sweats	Eye pain	Hearing loss	Palpitation	wheezing	Diarrhea	Urinary frequency
Body aches	Eye drainage	Hoarseness	Leg swelling	Blood in sputum	Constipation	Weak flow
Weight gain	Red eye	Congestion	Varicose veins		Abdominal pain	Urinary incontinence
Weight loss	Light sensitivity	Ringing in ear	Cold feet		Acid reflux	Vaginal discharge/itching

Musculoskeletal	Skin/Breast	Neurological	Endocrine	Hematologic	Psychological	Male
Joint pain	Rash	Fainting	Heat/cold intolerance	Bruising	Anxiety	Erectile dysfunction
Back pain	Itching	Headache	Excessive thirst	Bleeding	Depression	Loss of libido
Muscle pain	Mole	Numbness	Hair loss	Anemia	Bipolar	Penile discharge
Joint Stiffness	Breast mass	Seizure	Sweating	Enlarged Lymph nodes	Sleep disturbance	
Extremity pain	Breast tenderness	Memory loss	Excessive hunger		Severe stress	

Others:____