

# Integrated Family Medicine

## MEDICAL HISTORY

DATE:        /        /

### PERSONAL INFORMATION

Name: _____ Address: _____ _____ Occupation: _____ SS#: _____	Age: _____ Birthdate: _____ / _____ / _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Home Phone: (_____) _____ Work Phone: (_____) _____ Emergency Contact: _____ Phone: (_____) _____
<input type="checkbox"/> <b>Single</b> <input type="checkbox"/> <b>Married</b> _____ <span style="margin-left: 150px;">Spouse's Name</span>	
<input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Separated</b>	

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

### PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please indicate if you have had problems with (past) or presently complaining of (now) any of the following:

Past	Now	Past	Now	Past	Now	Past	Now
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	<input type="checkbox"/>	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/> Skin Disease
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> TB	<input type="checkbox"/>	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/> Venereal Diseases
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Colitis	<input type="checkbox"/>	<input type="checkbox"/> Anxiety
<input type="checkbox"/>	<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/>	<input type="checkbox"/> Changes in bowel habits	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> Indigestion	<input type="checkbox"/>	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/> Head/Neck radiation	<input type="checkbox"/>	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/> Palpitations	<input type="checkbox"/>	<input type="checkbox"/> Vomiting	<input type="checkbox"/>	<input type="checkbox"/> Headache	<input type="checkbox"/>	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/> Constipation	<input type="checkbox"/>	<input type="checkbox"/> Kidney disease	<input type="checkbox"/>	<input type="checkbox"/> Gout
<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/>	<input type="checkbox"/> Kidney stones	<input type="checkbox"/>	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/> Blood in stool	<input type="checkbox"/>	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Ulcers	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Bronchitis	<input type="checkbox"/>	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/> Low back problems	<input type="checkbox"/>	<input type="checkbox"/> Other

- Do you follow any specific diet?  Yes  No    If yes, what diet? \_\_\_\_\_  
 (for example, diabetic, low salt)
- Do you exercise on a regular basis?  Yes  No    If yes, please explain \_\_\_\_\_

### IMMUNIZATION HISTORY – have you had the following:

Hepatitis A? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____	Pneumococcal Immunization? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____
Hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____	Flu Immunization? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____
Other? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____	Tetanus Immunization? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____
	PPD (Tuberculosis Test)? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____

### GYNECOLOGIC AND OBSTETRIC HISTORY:

Age of onset of periods:	Frequency:	Length of period:
Pregnancies:	Births:	Miscarriages:

### SCREENING HISTORY:

When was your last pap smear? \_\_\_\_\_      Breast Exam? \_\_\_\_\_      Mammogram? \_\_\_\_\_

When was your last lab work? \_\_\_\_\_      Dexa Scan? \_\_\_\_\_      Colonoscopy? \_\_\_\_\_

When was your last Flexible Sigmoidoscopy? \_\_\_\_\_      Occult Blood Stool Testing? \_\_\_\_\_

Are you under any other physician's care?  Yes  No    (if yes, please list name/s) \_\_\_\_\_

Referred by: \_\_\_\_\_

**PLEASE COMPLETE NEXT PAGE**

PATIENT NAME: \_\_\_\_\_

DATE: / /

PLEASE LIST CURRENT MEDICAL CONDITIONS:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

PLEASE LIST & SUPPLY THE DATES OF:

SURGERIES: \_\_\_\_\_

Hospitalizations other than for surgery: \_\_\_\_\_

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	Living or Deceased?
Cancer (describe type)			
Hypertension (high blood pressure)			
Heart Disease			
Diabetes			
Strokes			
Mental Disease (anxiety, depression, etc.)			
Drug or Alcohol Addiction			
Glaucoma			
Bleeding Diseases			
Other:			

CURRENT MEDICATIONS (Prescription, Over-The-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Freq.	Drug Name	Dose	Freq.

PREVENTION

Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, why: _____
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much: _____
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much: _____
Do you drink coffee/soda?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much: _____
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much: _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you use drugs? (Marijuana, cocaine, crack, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, why _____
Have you ever engaged in any activity, which has put you at risk of getting AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, why _____
Do you wish to be tested for AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you in a relationship, which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a "living will"?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your method of birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby authorize Integrated Family Medicine physicians to release any medical information that may be necessary for either medical care or insurance company.

Signature: \_\_\_\_\_

Integrated Family Medicine

Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_