MedCare

Medical History

Patient Name: _____ Date of Birth: _____ Date: _____

List current/previous doctors and their specialty: _____

_____

_____

ALLERGIES AND REACTIONS	MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control, etc.)

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ☐ Alcohol/Drug addiction
- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ Cancer (type)
  - ☐ Breast ☐ Ovarian
  - ☐ Colon ☐ Uterine
  - ☐ _____
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ Crohn's disease
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hemorrhoids
- ☐ Hepatitis B or C
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney disease
- ☐ Kidney stone
- ☐ Liver disease
- ☐ Rheumatoid arthritis
- ☐ Seizure
- ☐ Sexually transmitted disease (type): _____
- ☐ Sickle cell disease
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Positive) TB
- ☐ Ulcerative colitis
- ☐ Urinary tract infections
- ☐ Other: _____ _____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ☐ Adopted

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters 1) ☐ M ☐ F			
2) ☐ M ☐ F			
3) ☐ M ☐ F			
Sons and Daughters 1) ☐ M ☐ F			
2) ☐ M ☐ F			
3) ☐ M ☐ F			

SOCIAL HISTORY

Occupation: Marital Status: Children: ☐ Y ☐ N

Do you drink alcohol? ☐ Y ☐ N How often? How many drinks?

Do you smoke? ☐ Y ☐ N Packs per day: ☐ ¼ pack ☐ ½ packs How many years? _____

Are you a former smoker? ☐ Y ☐ N ☐ ½ pack ☐ 2 packs Year quit? _____

Do you chew tobacco ☐ Y ☐ N ☐ 1 pack ☐ Other _____

Do you use recreational/illegal drugs? ☐ Y ☐ N

Have you worked with asbestos or other hazardous materials? ☐ Y ☐ N

Do you have a living will? ☐ Y ☐ N Healthcare proxy? ☐ Y ☐ N
Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period: _____ Last pap smear: _____ Last mammogram: _____

Last colonoscopy: _____ Last prostate cancer screening: _____ Last bone density scan: _____

Immunizations: ☐ Covid-19: _____ ☐ Flu: _____ ☐ Hep A: _____ ☐ Hep B: _____
☐ Pneumovax: _____ ☐ Shingles: _____ ☐ Tetanus: _____ ☐ Other: _____

REVIEW OF SYMPTOMS (please check if you have recently had the following symptoms):

☐ Weight gain	☐ Persistent cough	☐ Blood in stool	☐ Headaches
☐ Weight loss	☐ Chest discomfort	☐ Difficulty urinating	☐ Memory loss
☐ Night sweats	☐ Palpitations	☐ Trouble holding urine	☐ Numbness/Tingling
☐ Weakness	☐ Fainting	☐ Frequency of urination	☐ Tremor
☐ Fatigue	☐ Change in exercise tolerance	☐ Penis discharge	☐ Uncontrollable mood swings
☐ Insomnia	☐ Difficulty swallowing	☐ Vaginal discharge/bleeding	☐ Anxiety
☐ Change in hearing	☐ Indigestion or heartburn	☐ Nipple discharge	☐ Depression
☐ Change in vision	☐ Nausea	☐ Breast pain	☐ Skin rash
☐ Runny nose	☐ Vomiting	☐ Breast lump	☐ Back pain
☐ Nose bleed	☐ Constipation	☐ Pain with intercourse	☐ Leg pain
☐ Fever	☐ Diarrhea	☐ Feeling too hot	☐ Leg swelling
☐ Blood in sputum	☐ Change in bowel habit	☐ Feeling too cold	☐ Other: _____
☐ Shortness of breath	☐ Blood in vomit	☐ Dizziness	_____

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

_____ _____ _____
Patient/Designee signature Patient name (PRINT) Date

_____ _____
Relationship to patient Reason patient is unable to sign