

**FAMILY CARE NOW
MEDICAL HISTORY FORM**

FAMILY HISTORY Do any relatives have any of the following illnesses?

CIRCLE AND INDICATE WHICH FAMILY MEMBER (Mother, Father, Sister, Brother, Aunt, Uncle)

Heart Disease _____ Stroke _____ High Blood Pressure _____
 Allergy _____ Asthma _____ COPD _____
 Diabetes _____ Cancer _____ Bleeding/clotting disorder _____

YOUR PAST MEDICAL HISTORY: Do you have any of the following illnesses? **PLEASE CIRCLE**

Diabetes Heart Disease Heart Murmur High Blood Pressure Myocardial Infarction
 COPD Asthma Tuberculosis Kidney Stones Renal Failure
 Stroke Seizures Arthritis Seasonal Allergies Thyroid Problems
 Ulcers Acid Reflux Hepatitis Irritable Bowel Bleeding/Clotting Disorder
 Cancer _____(type) Female: Last Menstrual Period _____(date)

Social History:

Do you smoke? Yes No
 How much per day _____
 Do you drink alcohol? Yes No
 How many drinks per week? _____

No known drug allergies (check box if no medication allergies)

Please list any allergies to medications:

Please list any surgeries (dates) you have had:

Please list any medications that you are taking (Amounts and times per day. Include vitamins and herbal products)

Review of Systems
PLEASE CHECK (✓) ANY CURRENT PROBLEMS YOU HAVE FROM THE LIST BELOW

CONSTITUTIONAL Fever/Chills/Sweats _____ Weight Loss/Gain _____ Fatigue/Weakness _____	ALLERGY Environmental _____ Sneezing _____ Runny nose _____ Itching _____	NEURO Headache _____ Dizziness _____ Weakness _____ Numbness/Tingling _____ Vision Changes _____ Hearing Loss/Ringing _____	HEENT Nasal congestion _____ Hoarseness _____ Sore Throat _____ Nasal drainage _____ Difficulty swallowing _____ Eye pain/discharge _____
RESPIRATORY Cough/Wheezing _____ Shortness of breath _____ Coughing blood _____	CARDIAC Chest pain/discomfort _____ Palpitations _____	GASTROINTESTINAL Abdominal pain _____ Nausea /vomiting _____ Heartburn/indigestion _____ Diarrhea _____ Constipation _____	URINARY Frequent urination _____ Burning/Pain _____ Blood in urine _____ Discharge _____
BLOOD/LYMPH Swollen glands _____ Night Sweats _____ Bleeding/bruising _____	MUSCULOSKELATAL Joint aches _____ Muscle aches _____ Swelling _____ Pain _____	SKIN Rash _____ Hives _____ Itching _____ Sores _____	ENDOCRINE Intolerance: heat/cold _____ Changes in skin/hair _____ PSYCH Depression _____ Anxiety/panic _____

PATIENT NAME:

DATE: