Four Oaks Medical Clinic

Medical History Form

Patient name: _____ Date of Birth: _____ Today's Date: _____

ALLERGIES

Allergies: ☐ No ☐ Yes, please list:

Drug Name	*Drug Reaction*

CURRENT MEDICATIONS **(include over the counter medications, herbals, supplements, etc. Also include any medications for pain, sleep or anxiety that are used on an as needed basis)**

Name	*Dose strength*	*How often taken*

PERSONAL FAMILY HISTORY

	Personal History	***Family History***	*Maternal (M) Paternal (P)*
Acid Reflux	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Cancer, types	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Lung Disease (COPD)	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
CVS (Stroke)	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Diabetes Mellitus	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Headaches, migraine	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Osteoarthritis	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Osteoporosis	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Sexually Transmited Disease Describe: _____	☐ Yes ☐ No		
Environmental Exposure	☐ Yes ☐ No		

Continued on 2nd Page

ADVANCE DIRECTIVES	Living Will ☐ Yes ☐ No	Organ Donation ☐ Yes ☐ No	Durable Power of Attorney: ☐ Yes ☐ No Who? _____

GYNECOLOGICAL HISTORY ***FOR WOMEN ONLY***			
#Pregnancies:	# Live births:	# Miscarriages:	# Abortions:
# of Vaginal Deliveries: _____ # of C-Sectrion Deliveries: ____	Pregnancy complications: ☐ Yes ☐ No If yes, please list		Age at first Menstrual Period: _____ Age at Memopause: _____
Date of last Pap Smear _____ Results: ☐ Normal ☐ Abnormal	Date of last mammogram: _____ Results: ☐ Normal ☐ Abnormal		Date of last Bone Density: _____ Results: ☐ Normal ☐ Abnormal

HOSPITALIZATIONS

Reason for Hospitalization	*Date of Hospitalization*	*Hospital/Physician*

SURGICAL HISTORY

Type of Surgery	*Date of Surgery*	*Hospital/Physician*

Procedures	*Date of Procedure*	*Hospital/Physician*
Colonoscopy		
Heart Catheterizations		
Other		

FAMILY HISTORY

	Alive?	*Birth Year*	*Age at Death*	*Cause of Death*
Father	☐ Yes ☐ No			
Mother	☐ Yes ☐ No			
	How many?	*# Alive*	*Birth Year(s)*	*If deceased, age & cause of death*
Brother(s)				
Sister(s)				
Children Sons				
Daughters				

SOCIAL HISTORY

Occupation:					
Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Hobbies/Recreation: (please list)					
		Frequency	*Quality*	*Type*	*For Past Use: Date Quit*
Exercise:	☐ Yes ☐ No				
Tobacco:	☐ Never ☐ Present ☐ Past				
Alcohol:	☐ Never ☐ Present ☐ Past				
Caffeine:	☐ Yes ☐ No				
Drug Use	☐ Never ☐ Present ☐ Past				

IMMUNIZATIONS

Date of Last Tetanus: _____ Date of Last Pneumovac: _____ Date of Last Flu Vaccine:_____

Date of Last Shingles Vaccine: _____

Continued on 3rd Page

OTHER MEDICAL PROVIDERS		
Name:	Speciality:	Phone #:
Name:	Speciality:	Phone #:
Name:	Speciality:	Phone #:

Signature: _____ Printed Name: _____ Date: _____