**Four Oaks Medical Clinic**

**Medical History Form**

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| Patient name: | |  | | | | | | Date of Birth: | | |  | | | | | | | Today’s Date: | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| ***ALLERGIES*** | | | | | | | | | | | | | | | | | | | | |
| Allergies: No Yes, please list: | | | | | | | | | | | | | | | | | | | | |
| *Drug Name* | | | | | | | | | | | | | | | | *Drug Reaction* | | | | |
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| ***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* | | | |
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| ***PERSONAL FAMILY HISTORY*** | | | | | | | | | | | | | | | | | | | | |
|  | | | | ***Personal History*** | | | | | | ***Family History*** *Maternal (M) Paternal (P)* | | | | | | | | | | |
| Acid Reflux  Asthma  Cancer, types  Lung Disease (COPD)  CVS (Stroke)  Diabetes Mellitus  Headaches, migraine  Heart Disease  High Blood Pressure  High Cholesterol  Kidney Disease  Osteoarthritis  Osteoporosis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sexually Transmited Disease  Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Environmental Exposure | | | | Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No | | | | | | Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No | | | | Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| ***Continued on 2nd Page*** | | | | | | | | | | | | | | | | | | | | |
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| **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* | | | |
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| ***SURGICAL HISTORY*** | | | | | | | | | | | | | | | | | | | | |
| *Type of Surgery* | | | | | | | *Date of Surgery* | | | | | | | | | | *Hospital/Physician* | | | |
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| *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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

02-10-2018