**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 RefluxAsthmaCancer, typesLung Disease (COPD)CVS (Stroke)Diabetes MellitusHeadaches, migraineHeart DiseaseHigh Blood PressureHigh CholesterolKidney DiseaseOsteoarthritisOsteoporosisOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sexually Transmited DiseaseDescribe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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*** |
|  |
| **ADVANCE DIRECTIVES** | Living Will Yes No | Organ Donation Yes No | Durable Power of Attorney: Yes NoWho? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***GYNECOLOGICAL HISTORY* \*FOR WOMEN ONLY\*** |
| #Pregnancies: | # Live births: | # Miscarriages: | # Abortions: |
| # of Vaginal Deliveries: \_\_\_\_\_\_\_# of C-Sectrion Deliveries: \_\_\_\_ | Pregnancy complications: Yes NoIf 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) |  |  |  |  |
| ChildrenSons |  |  |  |  |
| 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