Your Private MD

Medical History Form

Patient Name: ____ Age: ________

Date of Birth: _______________________________________

Allergies to Medications: ____

Medications: See attached form to list medications

Medical History:

Past Medical History (list all Illnesses):

____

____

____

____

Past Surgeries (include year if known):

____

____

____

____

Hospitalizations (include year and reason if known):

____

____

____

____

Other Medical Procedures Done:

____

____

____

____

Date: __________ Initial: __________

Preventative: Please list the most recent date of the following tests (if applicable):

Colonoscopy: ____________________
Pap smear: ____________________
Bone Density: ____________________
Mammogram: ____________________
Prostate Exam: ____________________
Shingles Vaccine: ____________________
Pneumonia Vaccine: ____________________
Flu Vaccine: ____________________
Tetanus Vaccine: ____________________

Social History:

Marital Status: Single / Married / Divorced /Widowed / Partner

Are you sexually active? Yes / No If yes, what type of contraception? ________________________

Sexual Preference: Heterosexual / Homosexual / Bisexual / Transsexual / Other _____________

Do you live: In your own home / Apartment / Assisted Living / Nursing Home /
Other ___________________

With whom do you live: ____

Employment Status: Employed / Self-Employed / Not Employed / Disabled / Retired

Name of Employer: _____________________________ Title/Role: ________________________________

Do you smoke? Yes / No If yes, what do you smoke? _______________________________

Number of Years Smoked? __________ Quit Date ___________________________

Do you drink alcohol? Yes / No If yes, what do you drink? ________________________________

Amount and How Often: _____________________ Quit Date ___________________________

Any Drug Use? Yes / No If yes, what and how often: ______________________________

Do you exercise? Yes / No If yes, what type and how often: __________________________

Do you wear a seatbelt? Always / Most of the Time / Sometimes / Never

Living Will? Yes / No Healthcare Power of Attorney? Yes / No

Date: _________ Initial: _________

Family History:

Mother: Living / Deceased Age: ___________ Cause of Death: ______________________________

Medical Illnesses:

____

____

Father: Living / Deceased Age: ___________ Cause of Death: ______________________________

Medical Illnesses:

____

____

Siblings: Number of Brothers: _____ Number of Sisters: _____ Age Ranges: ___________

Medical Illnesses:

____

____

Children: Number of Sons: _______ Number of Daughters: _______ Age Ranges: ___________

Medical Illnesses:

____

____

Notable Extended Family History:

____

____

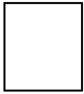
Name of Specialist(s)	**Specialty**
____	______________________________
____	______________________________
____	______________________________
____	______________________________

Date: __________ Initial: __________

How did you hear about our practice? ____

Name of Previous Primary Care Physician: ____

______________________	______________________	______________________
Patient Signature	Type Patient Name	Date

 Reviewed by Dr. Love-Walker

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Date

Date: __________ Initial: __________