Sound Medical Family Practice

MEDICAL HISTORY

Date: _____-_____-_____

Patient Name:_____DOB:_____-____-_____

Sex: o Male oFemale

Prior Family Physician/Provider

Physician/Provider Name:_____Phone ( ) _____-____

Address _____City_____ Zip_____ Fax ( )_____-_____

(Please obtain medical records from this provider. Please bring records on your first appointment)

Medication allergies and type of reaction:

Name of medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Medications and doses you are currently taking:

Please list over the counter meds/supplements also

Name of Medication	MG	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy: _____City_____Phone ( )_____-_____

Past Medical History Please check all that apply to you

Cardiovascular ___High blood pressure ___Heart Arrhythmia what kind_____
___Congestive Heart Failure
___ High cholesterol Heart attack when?_____
____Peripheral vascular disease

Pulmonary ___Asthma ____Bronchitis ___COPD ___ Pneumonia
___Pulmonary embolism what year? _____age_____

___Tuberculosis what year? _____ age_____

Gastrointestinal __GERD what year? ____ age___
__Crohn's Disease what year?____age___
__diverticulosis __Hepatitis (circle) A B C what year?_____age___
__Stomach ulcers __Heartburn

Renal ___Acute renal failure what year? ____age___ ___Kidney disease –Stage_____what year?___
___Kidney stone what year? _____age____ Current Creatinine level? _____

Musculosketal __Rheumatoid arthritis __Gout __Osteoporosis __Osteoarthritis

Endocrine __Prediabetes __Diabetes **I or II** what year?___ age___
__Thyroid disease what year? ____ __Osteoporosis

Neurological __ADD what year? _____age____ __Alzheimer's/Dementia what year?____age__
__Cerebral Palsy __Stroke what year_____ what age?_____
__Tension headaches __Migraine headaches
__Multiple Sclerosis __Restless leg syndrome __Seizure disorder

Hematologic __ Hemolytic anemia __Iron deficiency anemia __Pernicious (b12 deficiency) anemia
__Sickle cell anemia __Myelofibrosis

Allergy/Immunology _Seasonal allergies testing year_____ what triggers_____
__Eczema what year? _____age____ __Sinusitis

Cancers What part of the body_____what year?____Status?_____

Vision ___Cataract __Right __Left __Bilateral __Glaucoma

Hearing ___Loss of hearing __Right __Left __ Bilateral

Weight Current Weight # _____ as of what date?_____/____/_____

Hospitalizations _____check here if you have never been hospitalized

Date___/___/___ For what?_____Name of hospital_____

Date___/___/____For what?_____ Name of hospital_____

List any other specialist you are currently seeing

Name_____Speciality_____
Name_____Speciality_____

Advanced Directives Do you have any of the following?
___Living Will ___Durable Power of Attorney ___Do Not Resuscitate

Sound Medical
Family Practice **Last Name**_____, **First**_____

Preventative Health Screening

Please provide the date you last had the following test or service

__Flu Shot ___/___/____ __Pneumonia 23 Shot ___/___/____ __Prevnar 13 ___/___/____

__Zostavax (shingles vaccine) ___/___/____ __Tetanus Shot ___/___/____

__Colonoscopy ___/___/____ __Bone Density ___/___/____ __Eye Exam___/___/____

Women: __Last Mammogram ___/___/____ (please circle) Normal Abnormal
__ Last Pap Smear ___/___/____ (please circle) Normal Abnormal
Men: __ Last PSA ___/___/____

Surgical History

Check all that apply

- o Appendix what year?_____
- o Arthroscopy which joints_____what year?_____
- o Biopsy –what part of body_____ what year?_____
- o Coronary Bypass - What year?_____
- o Cataract
- o Hysterectomy __Total __Partial Year_____ Why?_____
- o Gallbladder
- o Joint Replacement Which joint (s)_____
- o Other_____what year?_____

Family Medical History

Father

- o Medical History Unknown
- o Medical History Unremarkable
- o Deceased Cause of death?_____what age?____

Check any that apply to your father's health

__Heart - What type of heart problems_____

__Stroke __Cancer - What kind of cancer_____

__Lungs __Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse what drugs_____ __Depression __Bipolar __Mental Illness

Mother

- o Medical History Unknown
- o Medical History Unremarkable
- o Deceased Cause of death?_____what age?_____

Check any that apply to your Mother's health

__Heart –What type of heart problems_____

__Stroke __Cancer - What kind of cancer_____

__Lungs __Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse what drugs_____ __Depression __Bipolar __Mental Illness

Brother - How many brothers do you have?_____

- o Medical History Unknown
- o Medical History Unremarkable
- o Deceased Cause of death?_____what age?____

Check any that apply to your brother's health

__Heart – What type of heart problems_____
__Stroke __Cancer - What kind of cancer_____

__Lungs ____Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse-what drugs_____ __Depression __Bipolar __Mental Illness

Sister - How may sisters do you have?_____

- o Medical History Unknown
- o Medical History Unremarkable
- o Deceased Cause of death?_____what age?____

Check any that apply to your sister's health

__Heart – What type of heart problems_____

__Stroke __ Cancer - What kind of cancer_____
__Lungs ___Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse -what drugs_____ __Depression __Bipolar __Mental Illness

Social History

What's your occupation: _____o Current o Retired year? _____

Marital Status: oSingle o Married o Separated o Divorced o Widowed o Widowed/Remarried
Number of children _____Step Children_____Foster Children_____

What are your hobbies: _____
What kind of exercise do you do?_____How often?_____ day or week

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacist? (Please circle one below)

1. Never 2- Rarely 3- Sometimes 4- Often 5- Always

Tobacco/ Caffeine/Alcohol/ Supplements

Tobacco use o Never Smoked o Past Smoker Quit Date __/__/__ Smoked how many years?__

Type of tobacco

- o Cigarettes –how many per day _____ cigarettes / packs (please circle)
- o Cigars- how many per day _____
- o Pipe-how many per day_____
- o Smokeless Tobacco –how many per day_____
- o Marijuana- how many times per day_____

Caffeine use

- o Coffee – servings per day _____
- o Tea- servings per day ____
- o Soda- servings per day ____ o Chocolate – how many servings per day_____

Alcohol Consumption o Never o Social o Regular Use o Member of AA
o Former member of AA

Type of Alcohol

o Beer – servings per day_____ per week_____
o Malt Liquor – servings per day _____ per week_____
o Wine – servings per day _____ per week_____
o Liquor – servings per day _____ per week_____

Supplements o None o Appetite Suppressants o Multivitamins

Do you follow a specialized diet? o Yes o No o If yes, which one?_____

Substance use

Do you use recreational drugs? o Never o Regular Use o Past –what year?_____

o Narcotics o Marijuana o Cocaine o Heroin o Opium o Other _____

How often do you use _____times a **day or week** (circle one)
Method of use o Smoke o Injection o Snort o Huff

Mental Health History

Do you suffer from any of the following?

- o **Anxiety** o Acute Stress Disorder o Panic Attacks o PTSD o Phobias
- o **Cognitive Disorder** o Alzheimer's o Dementia
- o **Eating Disorder** o Anorexia o Bulimia
- o **Mood Disorder** o Depression o Bipolar o Manic Episode
- o **Schizophrenia/Psychosis** o Paranoid o Disorganized o Residual
- o **Sleep Disorder** o Insomnia o Narcolepsy

Have you ever had environmental/chemical exposures or communicable diseases?
o Yes o No
If yes, what were you exposed to or what communicable disease?_____

To the best of my knowledge, I have provided you my medical history.

X _____ **Date** ____/____/_____

Patient's Signature