Annandale Family Practice – Medical History Form

In order to ensure that we are aware of your complete medical history and to better assess your individual risk factors, please take a few minutes to answer these questions.

Name: _____ Date: _____
Date of Birth: _____ Spouse/Significant Other: _____

Other Household Members: (Name, age, and relation)
_____
_____
_____

Medical/Psychiatric History: (Age at onset)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Previous Surgeries or Hospitalizations: (please state year)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Health Maintenance: (most recent)
Flu vaccine: _____ Pneumococcal Vaccine: _____ Tetanus: _____ Stress Test: _____ PSA (prostate): _____ Colonoscopy: _____ Pap test: _____
Mammogram: _____ Last menstrual period: _____

Medications: (include over the counters, herbals, supplements, and vitamins)

Name of Medication	Dose	Directions

Preferred Pharmacy: _____ **Phone** #:_____

Allergies: (medication, food, and environmental)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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Name: _____ Date: _____

Social History:
Are you: Married _____ Domestic Partner _____ Single _____ Divorced _____ Widowed _____
Occupation: _____ Employer: _____
Do you smoke? Y/N Type: _____ Packs/day: _____ Years smoked: _____
Do you drink alcohol? Y/N Type: _____ Amount: _____ Frequency: _____
Do you use illicit drugs? Y/N Have you used illicit drugs in the past? Y/N
Type: _____ Route: _____ Amount: _____ Frequency: _____ Last Use: _____
Do you have concerns for eating disorders? Y/N Domestic Violence? Y/N

Family History: (relation, age at diagnosis; if deceased, age at time of death)
Heart Disease: _____ High Blood Pressuse: _____
Heart Failure: _____ High Cholesterol: _____
Stroke: _____ Aneurysm: _____
Poor Circulation: _____ Amputation: _____
Emphysema: _____ Asthma: _____
COPD: _____ Chronic Bronchitis: _____
Cancer (type): _____ Oxygen used at home: _____
Diabetes: _____ Thyroid Disease: _____
Liver Disease: _____ Hepatitis: _____
Kidney Disease: _____ Kidney Failure: _____
Dementia: _____ Arthritis: _____
Other: _____
_____

Review of Symptoms: (circle all the symptoms that you have been experiencing)
Cardiac: chest pain, palpitations, pressure in the chest, heaviness in the chest, heart murmur
Lungs: shortness of breath, chronic cough, coughing up blood, wheezing
GI: nausea, vomiting, diarrhea, chronic constipation, hemorrhoids, blood in the bowels, black tarry stools, abdominal pain, pelvic pain, heart burn, indigestion, acid reflux
GU: difficulty urinating, blood in urine, pain with urination, urinary incontinence, frequent urination, waking at night to urinate, circumcision, bedwetting, daytime wetting
Reproductive: vaginal discharge, vaginal itching, heavy/painful/irregular periods, penile discharge, Age of first period _____ Last menstrual period _____
MS: Swelling in legs, chronic joint pain (If yes, which joint _____), back pain (chronic, recurrent), muscle aches, muscle deformity
Derm: lumps, bumps, moles of concern, rash, sores/lesions, tattoo, piercing
Neuro: numbness, tingling, tremor, seizure, convulsions, headaches (migraine, tension, cluster, sinus)
Eyes: vision loss, blurred vision, double vision, blindness
Wears: Glasses _____ Contacts _____ To drive/To read/All the time
Ears: hearing loss, vertigo, ringing in the ears, hearing aid (right/left/both), failed hearing screening
Nose: bloody nose, obstruction, deviated septum, snoring, post nasal drip
Throat: sore throat, lump in throat, change in voice, difficulty swallowing
Psych: depressed, moody, anxiety, panic attacks, hallucinations, tearfulness, lack of motivation
Gen: fever, chills, weight loss, weight gain, fatigue, lack of energy, change in appetite, change in sleep

Other: _____