



Medical and Family History Form
Please fill in the circles for the appropriate health information

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

REASON FOR VISIT _____

IF YOU HAVING A PROCEDURE AND HAVE HAD A HEART VALVE REPLACEMENT - CALL OUR OFFICE FOR INSTRUCTIONS.

Allergies

- O None O Codeine O Iodine O Morphine O Penicillin O Sulfa O Versed
O Aspirin O Demerol O Latex O Novocain O Propofol O Tape O Other _____

Past Medical Illnesses - Have you ever been treated for?

- O None O Gallstones O Back Pain O High Cholesterol O Phlebitis
O Anemia O Hepatitis A O Breast Cancer O High Triglycerides O Pneumonia
O Cirrhosis of Liver O Hepatitis B O Cancer O History of Suicide Attempts O Rheumatic Fever
O Colitis O Hepatitis C O Chronic Lung Disease O HIV/AIDS O Rheumatoid Arthritis
O Colon Cancer O Hiatal Hernia O Congestive Heart Failure O Irregular Heart Beat O Seizures
O Colon Polyps O Irritable Bowel Syndrome O Depression O Kidney Disease O Skin Cancer
O Crohn's Disease O Lactose Intolerance O Emphysema O Kidney Failure O Sleep Apnea
O Diarrhea O Pancreatitis O Frequent Urinary Tract Infection O Kidney Stone O Stroke
O Diabetes O Reflux O Glaucoma O Lupus O TB (Tuberculosis)
O Diverticulitis O Stomach Ulcer O Gout O Migraines O TB skin Test Positive
O Diverticulosis O Ulcerative Colitis O Heart Attack O Osteoarthritis O Thyroid Disease
O Duodenal Ulcer O Asthma O Heart Murmur O Paralysis O Uterine Cancer
O Fatty Liver O Atrial Fibrillation O High Blood Pressure O Parkinson's Disease
O Bleeding / Clotting Disorder O Heart Valve Infection (Endocarditis) O Other _____

On a regular basis, do you take:

- O Coumadin
O Plavix or other blood thinners
O Iron or vitamins with Iron
O Aspirin
O Nardil, Parnate, Eldepril, or MAO Inhibitors

Have you been told to take antibiotics prior to dental work or surgery because of a heart condition (YES/ NO)? If so, please specify:

Previous Surgeries

- | | | | | |
|---|---|--|--|--|
| <input type="radio"/> None | <input type="radio"/> Breast | <input type="radio"/> Heart Stent | <input type="radio"/> Kidney | <input type="radio"/> Tubal Ligation |
| <input type="radio"/> Colonoscopy | <input type="radio"/> C-Section | <input type="radio"/> Heart Valve Replacement - Type: Aortic / Mitral Mechanical / PIG | <input type="radio"/> Obesity Surgery | <input type="radio"/> Vasectomy |
| <input type="radio"/> EGD/Upper Endoscopy | <input type="radio"/> Cardiac Surgery | <input type="radio"/> Hemorrhoids | <input type="radio"/> Prostate | <input type="radio"/> Automatic Defibrillator Placement (Device that shocks the heart) |
| <input type="radio"/> ERCP | <input type="radio"/> Right Colon Resection | <input type="radio"/> Hiatal Hernia | <input type="radio"/> Stomach | |
| <input type="radio"/> Liver Biopsy | <input type="radio"/> Left Colon Resection | <input type="radio"/> Hysterectomy Partial | <input type="radio"/> Thyroid | |
| <input type="radio"/> Sigmoidoscopy | <input type="radio"/> Gallbladder | <input type="radio"/> Hysterectomy Total | <input type="radio"/> Tonsils | |
| <input type="radio"/> Appendix | <input type="radio"/> Heart Bypass Surgery | <input type="radio"/> Joint Surgery/ Replacement | <input type="radio"/> Transplant Surgery | <input type="radio"/> Other _____ |

Social History

Marital Status:

- Single Separated Married
- Divorced Widowed

Number of Children:

- 1 2 3 4 5 6+
- None

Exercise:

- I do not exercise I walk I jog I bike
- I swim I golf I do aerobics I lift weights

Alcohol:

- Never More than 2 days/week
- Rarely Less than 2 days/week
- Daily I quit using alcohol

Tobacco:

- I smoke Cigarettes
- 1 Pack per day
- 1 1/2 pack per day
- 2 packs per day
- Greater than 2 Packs per day
- I quit using tobacco products
- I have never used tobacco products
- I smoke Cigars
- I use Smokeless tobacco

Illicit Drug Use:

- I use illicit drugs I quit using illicit drugs I have never used illicit drugs Injection drug use

Occupation:

- Patient Occupation _____ Veteran Retired

Review of Systems - What symptoms are you currently having?

Gastrointestinal:

- | | | | | |
|---|--|---|--|--|
| <input type="radio"/> None | <input type="radio"/> black stools | <input type="radio"/> difficulty swallowing | <input type="radio"/> pain with bowel movement | <input type="radio"/> weight loss more than 10 lbs |
| <input type="radio"/> abdominal pain upper | <input type="radio"/> bloating | <input type="radio"/> flatulence/gas | <input type="radio"/> rectal bleeding | <input type="radio"/> weight gain less than 10 lbs |
| <input type="radio"/> abdominal pain lower | <input type="radio"/> change in bowel habits | <input type="radio"/> heartburn | <input type="radio"/> rectal urgency | <input type="radio"/> weight gain more than 10 lbs |
| <input type="radio"/> abdominal pain swelling | <input type="radio"/> constipation | <input type="radio"/> hemorrhoids | <input type="radio"/> reflux | <input type="radio"/> vomiting |
| <input type="radio"/> anal/rectal pain | <input type="radio"/> dairy intolerance | <input type="radio"/> mucus in stool | <input type="radio"/> soiling stool/incontinence | <input type="radio"/> other _____ |
| <input type="radio"/> belching | <input type="radio"/> diarrhea | <input type="radio"/> nausea | <input type="radio"/> weight loss less than 10 lbs | |

Review of Systems (continued)

Urinary:

- None
 - blood in urine
 - change in urinary frequency
 - kidney stones
 - nocturnal urination
 - pain with urination
 - sexually transmitted disease
 - urinary incontinence
 - Other _____
- Male**
- testicle problem
- Female**
- breast lump
 - heavy periods

Skin:

- NONE
- dryness
- hives
- itching
- jaundice
- rashes
- suspicious lesions
- Other _____

Cardiovascular:

- None
- ankle swelling
- chest pain with exertion/angina
- heart murmur as an adult
- palpitations
- shortness of breath when lying flat
- shortness of breath with exertion
- Other _____

Neurological:

- None
- dizziness
- fainting spells
- frequent headaches
- memory disturbance
- numbness in extremities
- seizures
- stroke/weakness
- tremors
- Other _____

Endocrine:

- None
- cold intolerance
- excessive thirst
- hair change/loss
- heat intolerance
- Other _____

Constitutional:

- None
- chills
- fatigue
- fever
- loss of appetite
- night sweats
- Other _____

Psychiatric:

- None
- anxiety/panic
- depression
- inability to concentrate
- suicidal thoughts
- Other _____

Eyes:

- None
- blurred vision
- cataracts
- glaucoma
- light sensitivity
- loss of vision
- pain
- wearing glasses/contacts
- Other _____

Hematologic:

- None
- easy bruising
- prolonged bleeding
- swollen glands
- Other _____

Ears, Nose and Throat:

- None
- hearing loss
- hoarseness
- nose bleeds
- sore throat
- Other _____

Review of Systems (continued)

Respiratory:

- None
- cessation of breathing when sleeping
- cough up blood
- shortness of breath
- coughing
- snoring
- wheezing
- Other _____

Family History

	Father	Mother	Child(ren)	Brother(s)	Sister(s)	Grand Parents
Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Age at diagnosis	_____	_____	_____	_____	_____	_____
Colon Polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crohn's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Esophageal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gall Bladder Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pancreas Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcer Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcerative Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	_____	_____	_____	_____	_____	_____

Medication Name

Dosages/Strength

Musculoskeletal:

- None
- back pain
- joint pain
- muscle pain
- stiffness
- Other _____

Immunologic:

- None
- allergies (environmental)
- HIV exposure
- immune deficiency
- persistent infections
- recurrent hives
- strong allergic reactions
- Other _____

Preferred Pharmacy

Name: _____

Location: _____

Phone: _____

(Attach additional pages if necessary)

Reviewed by:

Date:

Comments:
