**MIDDLETOWN FAMILY CARE ASSOCIATES, LLC**

**Patient Medical History Form**

**Patient Name**: **Date of Birth**: / /

To help the doctor serve you better, please complete the information below. Thank you!

**Allergies:** □ No known Allergies (If yes, please list all Drug, Food, and Environmental Allergies below :)

**Medications:** Preferred Pharmacy: Location:

Please list all current Over the Counter and Prescribed Medications with their corresponding dosages: (if known)

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME OF MEDICATION** | **STRENGTH** | **HOW OFTEN?** | **MONTH/YR STARTED** |
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**Personal Medical History:** Did you in the **Past**, or do you **currently** have problems with any of the following?

## (Please check all that apply to YOU)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONDITION** | **PAST** | **CURRENT** | **DATE/ AGE ONSET:** | **DATE/AGE RESOLVED:** |
| ABDOMINAL PAIN- CHRONIC |  |  |  |  |
| AGITATION |  |  |  |  |
| ALCOHOL ABUSE/ ADDICTION |  |  |  |  |
| ALLERGIES |  |  |  |  |
| ANEMIA |  |  |  |  |
| ARTHRITIS |  |  |  |  |
| ASTHMA |  |  |  |  |
| BACK PAIN-RECURRENT |  |  |  |  |
| BLEEDING EASILY |  |  |  |  |
| BLOOD IN URINE/HEMATURIA |  |  |  |  |
| BLOODY OR TARRY STOOLS |  |  |  |  |
| BONE FRACTURE OR JOIN INJURY |  |  |  |  |
| CANCER |  |  |  |  |
| CATARACTS |  |  |  |  |
| CHEST PAIN |  |  |  |  |
| CHICKEN POX |  |  |  |  |
| CHRONIC COUGH |  |  |  |  |
| CHRONIC FATIGUE |  |  |  |  |
| COLD NUMB FEET |  |  |  |  |
| COLITIS |  |  |  |  |
| CONSTIPATION |  |  |  |  |
| CROHN’S DISEASE |  |  |  |  |
| DECREASE IN FLOW OR FORCE OF URINE |  |  |  |  |
| DECREASED HEARING |  |  |  |  |
| DEPRESSION/MOODINESS |  |  |  |  |
| DIABETES |  |  |  |  |

**Date of Birth**: / /

***Patient Medical History Form*** *continued…*

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| **CONDITION**  **Patient Name**: | **PAST** | **CURRENT** | **DATE/ AGE ONSET:** | **DATE/AGE RESOLVED:** |
| DIARRHEA |  |  |  |  |
| DIFFICULTY SWALLOWING |  |  |  |  |
| DIVERTICULOSIS |  |  |  |  |
| DIZZY SPELLS |  |  |  |  |
| DOUBLE OR BLURRED VISION |  |  |  |  |
| DRUG ABUSE/ADDICTION |  |  |  |  |
| EAR INFECTIONS- FREQUENT |  |  |  |  |
| ECZEMA |  |  |  |  |
| EPILEPSY |  |  |  |  |
| EYE PAIN |  |  |  |  |
| FAILING VISION |  |  |  |  |
| FAINTING SPELLS |  |  |  |  |
| FEELINGS OF WORTHLESSNESS |  |  |  |  |
| FOOT PAIN |  |  |  |  |
| GALL BLADDER TROUBLE |  |  |  |  |
| GERMAN MEASLES |  |  |  |  |
| GLAUCOMA |  |  |  |  |
| GOUT |  |  |  |  |
| HEADACHES/MIGRAINE |  |  |  |  |
| HEART DISEASE |  |  |  |  |
| HEART MURMUR |  |  |  |  |
| HEARTBURN |  |  |  |  |
| HEMORRHOIDS |  |  |  |  |
| HERNIA |  |  |  |  |
| HERPES |  |  |  |  |
| HIGH BLOOD PRESSURE |  |  |  |  |
| HIGH CHOLESTEROL |  |  |  |  |
| HOARSENESS- PROLONGED |  |  |  |  |
| IRREGULAR PULSE/HEART PALPITATIONS |  |  |  |  |
| JAUNDICE/ HEPATITIS |  |  |  |  |
| KIDNEY STONES |  |  |  |  |
| LEG PAIN- WHEN WALKING |  |  |  |  |
| LOSS OF APPETITE – RECENT |  |  |  |  |
| LOSS OF CONTROL OF BLADDER-URINATION |  |  |  |  |
| MEASLES |  |  |  |  |
| MEMORY LOSS |  |  |  |  |
| MENTAL ILLNESS |  |  |  |  |
| MUMPS |  |  |  |  |
| NERVOUSNESS |  |  |  |  |
| NOSE BLEED- FREQUENT OR RECURRENT |  |  |  |  |
| NUMBNESS-TINGLING SENSATIONS |  |  |  |  |
| OSTEOPOROSIS |  |  |  |  |
| OTHER: |  |  |  |  |
| PAINFUL URINATION |  |  |  |  |
| PEPTIC ULCER |  |  |  |  |
| PERSISTENT NAUSEA/ VOMITING |  |  |  |  |

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| **CONDITION** | **PAST** | **CURRENT** | **DATE/ AGE ONSET:** | **DATE/AGE RESOLVED:** |
| PHOBIAS |  |  |  |  |
| PNEUMONIA/ PLEURISY |  |  |  |  |
| POLIO |  |  |  |  |
| PSORIASIS |  |  |  |  |
| RASHES/HIVES |  |  |  |  |
| RECENT HAIR LOSS |  |  |  |  |
| RECENT UNEXPECTED WEIGHT CHANGE |  |  |  |  |
| RHEUMATIC FEVER |  |  |  |  |
| RINGING IN EAR |  |  |  |  |
| SCARLET FEVER |  |  |  |  |
| SEVERE DEPRESSION |  |  |  |  |
| SHORTNESS OF BREATH WHILE ACTIVE |  |  |  |  |
| SHORTNESS OF BREATH WHILE AT REST |  |  |  |  |
| SINUS TROUBLE |  |  |  |  |
| SLEEPING DIFFICULTY |  |  |  |  |
| SORE THROAT- FREQUENT |  |  |  |  |
| STROKE |  |  |  |  |
| SUICIDAL IDEATIONS |  |  |  |  |
| SWOLLEN ANKLES |  |  |  |  |
| THYROID DISEASE |  |  |  |  |
| TREMOR |  |  |  |  |
| TROUBLE WITH CONCENTRATION |  |  |  |  |
| TUBERCULOSIS |  |  |  |  |
| URETHRAL DISCHARGE |  |  |  |  |
| URINATION MORE THAN TWICE AT NIGHT |  |  |  |  |
| URINE/BLADDER INFECTIONS – FREQUENT |  |  |  |  |
| VARICOSE VEINS/PHLEBITIS |  |  |  |  |
| VENEREAL DISEASE |  |  |  |  |
| WHEEZING |  |  |  |  |
| **OTHER:** |  |  |  |  |
|  |  |  |  |  |

**Procedures and Surgeries:** □ NONE (If yes, please list all Procedures/Surgeries and indicate when. Ex.: Tonsillectomy-2005

|  |  |
| --- | --- |
| **Procedure/ Surgery:** | **When:** |
|  |  |
|  |  |
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| --- | --- | --- |
| Last Colonoscopy | **DATE** | **PLACE/NAME OF DOCTOR** |
| Last Mammogram |  |  |
| Last Pap Smear |  |  |
| Last Eye Exam |  |  |
| Last Bone Density Scan |  |  |

***Patient Medical History Form*** *continued…*

**Family History:** Does any of the below condition apply to your relative(s)? If so, please mark (x) accordingly.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TYPE** | **MOTHER** | **FATHER** | **SISTER** | **BROTHER** | **Maternal**  **Grandmother** | **Maternal**  **Grandfather** | **Paternal**  **Grandmother** | **Paternal**  **Grandfather** |
| Alcohol Abuse |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |
| Bleeding Easily |  |  |  |  |  |  |  |  |
| Cancer:  1. |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |  |
| Headache/ Migraine |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |
| Severe Depression |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |
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**Social History:**

|  |  |  |
| --- | --- | --- |
| **ALCOHOL USE:** | TYPE (PLEASE CIRCLE) | AMOUNT AND FREQUENCY |
| * CURRENT □ PAST □ NEVER * QUIT SINCE: | Beer, Wine, Liquor  Other: |  |
| **TOBACCO USE:** | TYPE (PLEASE CIRCLE) | AMOUNT AND FREQUENCY |
| * CURRENT □ PAST □ NEVER * QUIT SINCE: | Cigarettes, Cigars, Snuffs, E-Cigarette Other: |  |
| **SUBSTANCE/DRUG USE:** | TYPE (PLEASE CIRCLE) | AMOUNT AND FREQUENCY |
| * CURRENT □ PAST □ NEVER * QUIT SINCE: | Marijuana, Cocaine, Heroin, Opioids Other: |  |

**Pregnancies:**

Please complete below for all pregnancies including abortions, miscarriages, etc.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE/ TIME** | **NUMBER OF WKS.**  **PREGNANT** | **PREGNANCY/ DELIVERY OUTCOME** | **LENGTH OF LABOR** | **SEX OF THE**  **BABY** | **WEIGHT** | **ANESTHESIA** | **HOSPITAL** |
| 1. |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |
| 5. |  |  |  |  |  |  |  |
| 6. |  |  |  |  |  |  |  |
| 7. |  |  |  |  |  |  |  |
| 8. |  |  |  |  |  |  |  |

□ NO

□ YES

**DO YOU HAVE A LIVING WILL or ADVANCED DIRECTIVE?**

This is to indicate your wishes in the event of clinical changes to your health.

Other Specialist(s) Seen Currently

|  |  |  |  |
| --- | --- | --- | --- |
| **TYPE OF SPECIALTY** | **REASON TO SEE SPECIALIST** | **PHYSICIAN/PRACTICE NAME** | **PHONE #** |
|  |  |  |  |
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I certify that the information contained herein is complete and accurate to the best of my knowledge.

Patient Signature Date

**Patient Name**: **Date of Birth**: / /

# Employment and Education

|  |  |  |
| --- | --- | --- |
| **Status:** | **Work Hazards:** | **Activity Level:** |
| □ Employed □ Retired |  |  |
| □ Disability □ Student | □ Hazardous Materials □ Repetitive | □ Desk/Office □ Moderate |
| □ Part-Time □ Unemployed | □ Heavy Lifting/Twisting Motion | □ Occasional Physical Work |
| Other: | * Loud Noises □ Shift/Night * Medical/Clinical Work Work | Physical Work □ Heavy Physical  Work |
| **Do you operate any hazardous equipment?** Y / N | □ Vibration  Other: | Other: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous Employment/School:** | **Highest Education:** | | **School Concerns:** |
| \_ | □ None | □ Bachelor’s Degree | * Learning □ Health * Social □ Cultural * Communication □ Other: Additional Information: |
|  | □ Elementary | □ Master’s Degree |
| \_ | School | □ Adv. Graduate or |
|  | □ High School/GED | Ph.D. |
| Additional Information: | □ Middle School |  |
|  | □ Some College |  |
| \_ |  |  |

**Home and Environment**

|  |  |  |
| --- | --- | --- |
| **Marital Status:** | **Lives With:** | **Living Situation:** |
| * Single □ Separate * Married □ Never Married * Married □ Divorce   (Living □ Widowed  Together) □ Annulled   * Life Partner | * Self □ Mother * Children □ Roomate(s)/ * Family Friend(s) * Father □ Siblings * Foster Family □ Significant Other * Grandparents □ Spouse | * Home/Independent * Home with Assistance Physical Work * Homeless/Shelter   Other:  **Number of Children:** |
| Other: | Other: |

|  |  |  |
| --- | --- | --- |
| *E n v i r o n m e n t* *S c r e e n i n g* | | |
| **Have you experience any abuse in your house hold?** | **Do you feel unsafe at home?** Y / N | **Have you notified any Agencies about your abuse?** Y / N |
|  | **Do you have a safe place to go?** Y / N |  |
|  |  | **Agency(s)/Others Notified:** |
| \_ | **Do you have Family/Friends available to help?** Y / N |  |

**Patient Name**: **Date of Birth**: / /

# Nutrition and Health

|  |  |  |
| --- | --- | --- |
| **Briefly write your routine diet:** | **Type of Diet:** | **OTHER:** |
|  | * Regular □ Low Fat * Calorie Restricted □ Low Sodium * Diabetic □ Renal * Dysphagia Diet □ Total Parenteral * Ketogenic Diet Nutrition * Kosher □ Vegetarian * Low Carbohydrate | Diet Restrictions:  Caffeine intake amount:  **Do you want to lose weight?** Y / N |
| Other: |  |

|  |  |  |
| --- | --- | --- |
| **Vitamins/Alternative Health** | **Eating Disorders:** | **OTHER:** |
| Vitamins/Supplements:  Uses Alternative Healthcare: | * Bulimia * Anorexia Nervosa * Overeating   Other: | **Sleeping concerns?** Y / N  **Feeling highly Stressed?** Y / N |

**Exercise and Physical Activity**

|  |  |  |
| --- | --- | --- |
| **Exercises** | **Exercise Type:** | **Self-Assessment** |
| **How many times per week?** | **Duration (Average # of minutes):** | * Poor Condition * Fair Condition * Good Condition * Excellent Condition   Other/Comment: |
| □ Never | □ Aerobics □ Running |
| □ 1-2 times | □ Bicycling □ Swimming |
| □ 3-4 times | □ Organized Team □ Walking |
| □ 5-6 times | Sports □ Weight Lifting |
| □ Daily | □ PE Class □ Yoga |
| Other: |  |
|  | Other: |

***Patient Medical History Form*** *continued…*

**Patient Name**: **Date of Birth**: / /

# Sexual Activity

|  |  |  |
| --- | --- | --- |
| **Activity** | **Orientation:** | **Contraceptive Use Details** |
| **Are you Sexually Active?** Y / N  **When were you first active? Age:**  **Number of lifetime partners**:  **Number of current partners**: | **Self-describe orientation:**   * Heterosexual □ Bisexual * Homosexual □ Transgender   Other:  **Do you use condoms?** Y / N | * Abstinence □ Condoms * Birth Control □ Intrauterine   Implant Device   * Birth Control PATCH □ Vaginal Ring * Birth Control PILL □ None * Birth Control SHOT   Other Contraceptive Use/Comment: |

|  |  |
| --- | --- |
| **History of Abuse** | **Other Related Concerns:** |
| **Have you ever been sexually abused?** Y / N  Comment: |  |