Holmes Family Medicine Medical History Form

Name:_____ Date of Birth:_____ Family Doctor:_____

Past Medical History

Medical Problems/Conditions:	Yes	No
Arthritis	☐	☐
Coronary Artery Disease	☐	☐
High Cholesterol	☐	☐
Hypertension (high blood pressure)	☐	☐
Heart Attack	☐	☐
Congestive Heart Failure	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Emphysema/COPD	☐	☐
Ulcers	☐	☐
Acid Reflux/GERD	☐	☐
Kidney Disease	☐	☐
Kidney Stones	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Seizures	☐	☐
Cancer (if yes, give type)	☐	☐

Other: _____

_____

_____

_____

_____

_____

Family History

Condition:	Yes	No	Family Member:
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Cancer (if yes, give type)	☐	☐	_____
Arthritis	☐	☐	_____
Autoimmune Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Bleeding Disorder	☐	☐	_____

Other: _____

_____

_____

_____

_____

Social History

Marital Status _____

Employment _____

Alcohol Consumption _____

Caffeine Consumption _____

Exercise _____

Smoking History ☐ Never ☐ Current ☐ Ex-smoker

Packs Per Day _____ _____

years (smoker or smoke free) _____ _____

Childbirth History

Number of Children _____

Number of Pregnancies _____

Vaginal Deliveries _____

Cesarean Deliveries _____

Surgical History:

Surgical History:	Year:	Hospital:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Colonoscopy/Endoscopy	_____	_____
Anesthesia Complications	_____	_____

Medication Use (dosage and frequency):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems (Current Symptoms)

GENERAL	***YES***	***NO***
weight changes		
appetite changes		
fever		
chills		
Night Sweats		
excessive daytime sleepiness		
awake from sleep choking/gasping		
SKIN	***YES***	***NO***
new/changing lesions/moles		
nail changes		
rashes		
itching		
tattoos		
HEENT	***YES***	***NO***
headaches		
vision changes		
cataracts or glaucoma		
hearing changes		
snoring or apnea (stop breathing)		
sore throat		
vertigo (dizziness)		
difficulty swallowing		
cold sores		
EMOTIONAL	***YES***	***NO***
depression		
anxiety		
trouble sleeping		
tired all the time		
sexual difficulty		
increased stress		
NEUROLOGIC	***YES***	***NO***
numbness		
weakness		
memory loss		
passing out		
unsteady gait		
CARDIAC	***YES***	***NO***
chest pain		
palpitations		
irregular heartbeat		
ankle swelling		
poor circulation		
sleep sitting up		
wake up short of breath		
RESPIRATORY	***YES***	***NO***
cough		
shortness of breath		
wheezing		

GASTROINTESTINAL	***YES***	***NO***
abdominal pain		
nausea		
acid reflux		
vomiting		
black stool		
hemorrhoids		
diarrhea		
constipation		
GENITO-URINARY	***YES***	***NO***
burning with urination		
blood in urine		
increased urinary frequency		
hesitancy		
dribbling		
lack of bladder control		
vaginal discharge		
penile discharge		
vaginal dryness		
Pain or bleeding with intercourse		
still having periods		
last menstrual period		
last pelvic exam		
MUSCULOSKELETAL	***YES***	***NO***
back pain		
joint pain		
muscle pain		
HEMATOLOGIC	***YES***	***NO***
easy bruising		
excessive bleeding		
anemic		
ADULT IMMUNIZATIONS	***DATE***	***NO***
flu		
pneumonia		
shingles		
tetanus		

New Problems or Concerns:
1.)
2.)
3.)
New Surgeries: