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: ______________________________________

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Surgical History:

Surgical History:	**Year:**	**Hospital:**
____________________	______	________
____________________	______	________
____________________	______	________
____________________	______	________
Colonoscopy/Endoscopy	______	________
Anesthesia Complications	______	________

Medication Use (dosage and frequency):

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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: ______________________________________

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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 ____________________________

Allergies

Medication	Reaction
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Review of Systems (Current Symptoms)

GENERAL	***YES***	***NO***
appetite changes		
awake from sleep choking/gasping		
excessive daytime sleepiness		
SKIN	***YES***	***NO***
new/changing lesions/moles		
itching or painful lesion		
HEENT	***YES***	***NO***
vision changes		
hearing changes		
snoring or apnea (stop breathing)		
sore throat		
vertigo (dizziness)		
difficulty swallowing		
NEUROLOGIC	***YES***	***NO***
numbness		
weakness		
passing out		
unsteady gait		
CARDIAC	***YES***	***NO***
chest pain		
palpitations		
irregular heartbeat		
sleep sitting up		
wake up short of breath		
RESPIRATORY	***YES***	***NO***
cough		
shortness of breath		
wheezing		

GASTROINTESTINAL	***YES***	***NO***
abdominal pain		
acid reflux		
vomiting		
black stool		
diarrhea		
constipation		
MALE GENITO-URINARY	***YES***	***NO***
blood in urine		
increased urinary frequency		
hesitancy		
Dribbling/leaking		
lack of bladder control		
FEMALE GENITO-URINARY	***YES***	***NO***
blood in urine		
increased urinary frequency		
hesitancy		
Dribbling/leaking		
lack of bladder control		
pain or bleeding with intercourse		
still having periods		
last menstrual period		
last pelvic exam		
HEMATOLOGIC	***YES***	***NO***
easy bruising		
excessive bleeding		
anemic		
NEW SURGERIES	***Date***	