

Hawthorne Medical Associates – MEDICAL HISTORY FORM

Form revised 2011.5

First Name:	Middle Initial:	Last Name:	Preferred Name:
Date of Birth:	Age:	Today's Date:	
Pharmacy Name & Location:		RACE: <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asia, India, Pakistan <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Refused to report	ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino
Pharmacy Phone #:			LANGUAGE PREFERENCE: <input type="checkbox"/> English Specify if not English:
Allergies (please list): Medications: _____ Food: _____ Other: _____		Preventive Health Reminders (PICK ONE): Preferred Notification Method: <input type="checkbox"/> Postal Mail (default) <input type="checkbox"/> Telephone <input type="checkbox"/> Web Message	
Immunizations: Date of last Tetanus shot: _____ Date of last Pneumonia shot: _____ Hepatitis B immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No Zostavax (Shingles vaccine)? <input type="checkbox"/> Yes <input type="checkbox"/> No Flu vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Family <u>Medical</u> History: (please list any medical problems, past or present)			
Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased at age _____ Medical Problems: _____			
Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased at age _____ Medical Problems: _____			
Brothers: # of brothers: _____ Medical Problems: _____			
Sisters: # of sisters: _____ Medical Problems: _____			
Children: # of children: _____ Medical Problems: _____			
Chronic Diseases: (please check any you have)			
<input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Blood clots (DVT/PE) <input type="checkbox"/> Cancer <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> COPD (pulmonary disease) <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Dementia <input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Fibrocystic breast disease <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> GERD (reflux disease) <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart problems <input type="checkbox"/> Heartburn <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Macular degeneration <input type="checkbox"/> Menopausal symptoms <input type="checkbox"/> Migraines <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Prostate problems <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other:	

Surgeries: (List DATES and DOCTORS)

Other Physicians and Healthcare Providers:

What other doctors do you see? What other health care providers or companies do you use?
If they are not in the Athens area, please list their location.

Preventive Health Services: (Please list the DATE of your most recent test)

Mammogram: _____ Rectal exam: _____
Pap Smear: _____ Prostate blood test (PSA): _____
Bone density test: _____ Colonoscopy: _____
Diabetics: Date of last dilated eye exam: _____ Name of Ophthalmologist: _____

Social History:

Do you use Tobacco? yes no stopped. When started? _____ When stopped? _____
Do you use Alcohol? yes no Describe: _____
Do you use recreational drugs: yes no stopped. Describe: _____
Do you exercise? yes no Describe: _____
State or Country of Birth: _____
Education: (Degree or highest grade in school): _____
Occupation (before retirement): _____
Do you use seat belts: yes no Hobbies: _____
Marital status: married divorced single separated widowed
Do you have a Living Will? yes no If yes, please bring a copy.
Do you have a Durable Power of Attorney for Healthcare? yes no If yes, bring a copy.

Travel History: Have you traveled out of the country recently? When? Where?

MEDICATIONS: Please list (or attach a list) of the Medications you currently take. We need to know the strength and how often you take it. Include over-the-counter and vitamins.

Review of Systems: Please answer all questions.

(For Office Use: Problem pertinent = 1 system, Extended=2-9 systems, Complete=10 systems)

<p>GENERAL:</p> <p>Fatigue YES NO Weight gain > 10 lbs YES NO Weight loss > 10 lbs YES NO</p> <p>SKIN:</p> <p>New spots or lesions YES NO Itching (pruritus) YES NO Rash YES NO</p> <p>HEENT:</p> <p>Decreased hearing YES NO Ringing in ears (tinnitus) YES NO</p> <p>NECK:</p> <p>Neck pain YES NO Swollen glands YES NO</p> <p>RESPIRATORY:</p> <p>Cough YES NO Shortness of breath YES NO Wheezing YES NO</p> <p>BREAST:</p> <p>Breast mass YES NO Breast pain YES NO</p> <p>DIABETES:</p> <p>Sugars controlled YES NO Visual problems YES NO Foot numbness/tingling YES NO Foot sores YES NO</p>	<p>CARDIOVASCULAR:</p> <p>Chest pain YES NO Swelling in arms/legs YES NO Palpitations YES NO</p> <p>GASTROINTESTINAL:</p> <p>Abdominal pain YES NO Change in bowel habits YES NO Constipation YES NO Heartburn YES NO Rectal bleeding YES NO</p> <p>MUSCULOSKELETAL:</p> <p>Joint pain YES NO Joint swelling YES NO Back pain YES NO</p> <p>NEUROLOGICAL:</p> <p>Headaches YES NO Seizures YES NO Dizziness YES NO</p> <p>Anxiety YES NO Depression YES NO Insomnia YES NO</p>	<p>ENDOCRINE:</p> <p>Appetite changes YES NO</p> <p>HEMATOLOGY:</p> <p>Anemia YES NO Enlarged lymph nodes YES NO</p> <p>MALE GENITOURINARY:</p> <p>Blood in urine YES NO Erection problem YES NO Nighttime urination YES NO Change in urinary stream YES NO</p> <p>FEMALE GENITOURINARY:</p> <p>Painful urination YES NO Blood in urine YES NO Vaginal discharge YES NO</p> <p>OTHER: (please list)</p>
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How likely are you to doze off or fall asleep during the following situations?

Use the following scale: 0 = would never doze
 1 = slight chance of dozing
 2 = moderate chance of dozing
 3 = high chance of dozing

- ___ Sitting and reading
- ___ Watching TV
- ___ Sitting, inactive in a public place
- ___ As a passenger in a car for an hour
- ___ Lying down in the afternoon
- ___ Sitting and talking to someone
- ___ Sitting quietly after a lunch without alcohol
- ___ In a car, while stopped for a few minutes in traffic

Total: _____