

Hawthorne Medical Associates – MEDICAL HISTORY FORM

Form revised 2010.8

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Allergies: Medications allergies (please list): _____ Food: _____ Other: _____	Pharmacy Name & Location:	
	Pharmacy Phone #:	
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)? Yes No	Race/Ethnicity:	
	<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> American Eskimo <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian (white) <input type="checkbox"/> Hispanic	<input type="checkbox"/> Indian (India & Pakistan) <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Mixed <input type="checkbox"/> Other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other
	Language Preference: <input type="checkbox"/> English Specify if not English: _____	

Family Medical History: (please list any medical problems, past or present)

Father: Living Deceased at age _____ Medical Problems: _____

Mother: Living Deceased at age _____ Medical Problems: _____

Brothers: # of brothers: _____ Medical Problems: _____

Sisters: # of sisters: _____ Medical Problems: _____

Children: # of children: _____ Medical _____

Chronic Diseases: (please check any you have)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Macular degeneration
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Menopausal symptoms
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Migraines
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibrocystic breast disease	<input type="checkbox"/> Obesity
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> GERD (reflux disease)	<input type="checkbox"/> Peripheral neuropathy
<input type="checkbox"/> Blood clots (DVT/PE)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Seizures
<input type="checkbox"/> COPD (pulmonary disease)	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dementia	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Other:

Surgeries: (List DATES and DOCTORS)

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: _____

Name:

Date:

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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

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)

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