Akwaaba Care
FAMILY PRACTICE

1450 East Street
Suite Seven
Pittsfield, MA 01201
ph 413.728.9801
fax 833.989.2283

Medical and Medication History

Name (First, MI, Last)_____

Date of Birth _____ Legal Sex: M F Preferred Pronouns_____

Number of Children and their ages_____

_____

Please circle all that apply, past or present

CONSTITUTIONAL
- weight gain
- weight loss
- loss of appetite
- fever
- weakness
- history of stroke
- history of angina or heart attack
- history of high blood pressure
- history of thyroid disease

GASTROINTESTINAL
- difficulty swallowing
- abdominal pain
- nausea/vomiting
- constipation
- diarrhea
- blood in stool
- change in bowel habits

EENT
- coughing blood
- nose bleed
- hearing loss
- change in voice
- sore throat
- ringing in ears
- snoring
- dental problems

NEUROLOGY
- headache
- tingling numbness
- seizures
- dizziness

OPHTHALMOLOGY
- drainage from eyes
- blurring of vision
- visual changes yes

RESPIRATORY
- shortness of breath
- persistent cough
- history of asthma
- history of COPD

DERMATOLOGY
- rash
- change in color of moles

GENITOURINARY
- painful urination
- increased urination
- decreased libido
- erectile dysfunction

MUSCULOSKELETAL
- joint swelling
- joint pain
- leg cramps
- joint stiffness

PSYCHOLOGY
- high stress level
- depression
- sleep disturbances

ENDOCRINOLOGY
- fatigue
- excessive sweating
- excessive thirst
- excessive urination

CARDIOLOGY
- chest pains
- palpitations
- leg swelling

WOMEN'S HEALTH
- irregular periods
- painful periods
- pain during sex

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Please describe any past medical problems, surgeries, or conditions of any kind that you have experienced:_____
_____
_____
_____
_____
_____

Please describe any current medical problems, surgeries, or conditions of any kind that you live with or have scheduled_____
_____
_____
_____
_____
_____
_____

Please describe your current mental health in general and list any difficulties you have experienced with depression, anxiety or other mental health condition_____
_____
_____
_____
_____
_____
_____

Please describe your family's history of heart disease, cancer, diabetes, blood disorders, mental health conditions, genetic abnormalities, chronic conditions, or any other disease that exists within your family_____
_____
_____
_____
_____
_____
_____

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Please describe your personal history pertaining to alcohol and substance use, including tobacco, cannabis, alcohol, street drugs, prescription medication misuse, etc, and provide the details of any detox or rehabilitation programs you have attended_____
_____
_____
_____
_____
_____
_____

Please list all medications you take, the dose and frequency, and indicate who they were prescribed by and when, see example:

Medication	Dose	Frequency	Prescribed By
metformin, 500 mg	2 tab	once daily	Dr Smith

I hereby certify that the above is true to the best of my knowledge.

Signed_____
Date_____
Printed name_____