Fox Medical Center Date __/__/___

Medical History Form:

Allergies: please list any food, medication or other allergies and the type of reaction you had

Allergic to:	Type of reaction: (rash, vomiting, etc)	Last time exposed

If you have more allergies, feel free to complete on the back of this page or provide a list of your own.

I have no known allergies. _____ (please initial)

Medications: please list all prescription and over-the-counter medications and supplements you take – include the dose and how often you take them.

Medication	Dose (ie, mg or units)	When	For what condition

If you have more allergies, feel free to complete on the back of this page or provide a list of your own.

Please check the conditions or organ systems for which you have had health issues in the past.

PERSONAL MEDICAL HISTORY TYPE – please circle and note if current or what year it occurred if it has resolved.

Asthma

Cancer (type:_____)

Depression/Anxiety/Bipolar/Suicidal

Diabetes (type:_____)

Emphysema (COPD)

Heart Disease / Heart attack

High Blood Pressure (hypertension)

High Cholesterol

Hypothyroidism/Thyroid Disease

Renal (kidney) Disease

Migraine Headaches / Seizures

Stroke

Other:

Other:

Please list any surgeries, when they occurred and which side was involved if appropriate.

Surgery	When	Left or Right

How many hours do you sleep at night? _____

Do you exercise regularly? Y/N What type of exercise, how often? _____

How would you rate your diet? Good / fair / poor. Would you like nutrition advice? _____

For WOMEN:

Last Menstrual Cycle: _____ Age of first menses _____ or menopause_____

Total number pregnancies: _____ Number of live births: _____ Any C-sections? _____

Are your menstrual cycles regular? Y / N Are you on any birth control? _____

For MEN:

Do you have any prostate problems? (getting up during the night, weak stream, frequency, urgency, difficult to start flow) Y/N Have you seen anyone for these issues? Y / N

Family History:

Please mark conditions that have been diagnosed in your family and who the relation is.

(mother, father, son, daughter, maternal/paternal grandmother/father (MGM,PGM,MGF,PGF), sibling)

Condition	Relation	Age when diagnosed	Still living?
Alcohol / drug Abuse			
Asthma			
Cancer (type_____)			
Emphysema / COPD			
Depression / Anxiety			
Bipolar / Suicidal			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood pressure			
Kidney Disease			
Stroke			
Seizure			
Thyroid Disease			
Migraine			
Other: _____			
Other: _____			
Other: _____			

Health Maintenance Screening History:

Date of last:

Mammogram: _____ where: _____ normal / abnl

Colonoscopy: _____ where: _____ normal / abnl

Pap Smear : _____ where: _____ normal / abnl

Chest xray/ CT (if smoker): _____ where: _____ normal / abnl

Cholesterol: _____ where: _____ normal / abnl

Bone density: _____ where: _____ normal / abnl

Last tetanus booster: _____ Last shingles shot: _____

Covid shot: _____ Last pneumonia shot: _____