**Medical History Today’s date\_\_\_\_\_\_\_\_\_**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

The questions below are to assists us in your *Quality of Care,* we do need to ask these questions yearly. We know that some of these questions do not pertains to you, but if you could please answer any that are applicable to you. Thank you

Are you in pain today? If yes on a scale of 1 to 10 (10 being the highest)? \_\_\_\_\_\_\_\_\_

Have you fallen in the last year? \_\_\_\_\_ Yes \_\_\_ No If yes how many times? \_\_\_\_\_\_

Do you feel unstable? \_\_\_\_\_\_\_ Yes \_\_\_ No Do you have muscle weakness? \_\_\_\_ Yes \_\_\_ No

Do you have little interest in doing things? \_\_\_\_ Yes \_\_\_ No Are you feeling depressed? Hopeless? \_\_\_\_\_ Yes \_\_\_No

**Past Medical History and Review of Systems**

Please check off if you have had any problems with or are presently experiencing any of the following:

* High Blood Pressure
* Diabetes
* Cancer
* Heart Disease
* Chest Pain/chest tightness
* Shortness of breath
* Swollen ankles
* Palpitations
* Lightheadedness
* Frequent urination
* Rheumatic fever
* Asthma
* Bronchitis
* Pneumonia
* Persistent cough
* T.B.
* Hay fever
* Abdominal discomfort
* Indigestion
* Nausea
* Vomiting
* Constipation
* Diarrhea
* Blood in stool
* Ulcers
* Change in bowel habits
* Unexplained weight loss/gain
* Hemorrhoids
* Gall Bladder disease
* Colitis
* Hepatitis or jaundice
* Thyroid disease
* Head or neck radiation
* Headache
* Kidney disease
* Difficulty urinating
* Arthritis
* Low back problem
* Skin disease
* Blood disorders
* Pelvic pain
* Venereal disease
* Anxiety
* Depression
* Anemia
* Gout
* Drug Abuse
* Alcohol Abuse
* Impotence or

Erectile Dysfunction

* Other

**Prevention**

Are you currently employed? \_\_\_ Yes \_\_\_ No Retired? \_\_\_

Do you wear seat belts? \_\_\_ Yes \_\_\_ No

Do you wear a bike helmet? \_\_\_ Yes \_\_\_ No

Do you diet? \_\_\_ Yes \_\_\_ No

Do you exercise regularly \_\_\_ Yes \_\_\_ No If yes, how often \_\_\_\_\_\_\_?

Do you caffeinate beverage \_\_\_ Yes \_\_\_ No If yes, how many cups per day \_\_\_\_\_\_

Are you in a relationship in which

you have been physical hurt? \_\_\_\_ Yes \_\_\_\_ No

Do you ever feel afraid at home? \_\_\_\_ Yes \_\_\_\_ No

Do you have a “Donor Card”? \_\_\_\_ Yes \_\_\_\_ No

Do you smoke? \_\_\_\_Yes \_\_\_\_ No, if yes how often \_\_\_\_\_\_\_\_\_

Have you ever smoked? \_\_\_\_ Yes \_\_\_\_ No Year stopped \_\_\_\_\_\_\_\_\_\_\_\_

Other tobacco use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcoholic beverages? \_\_\_\_Yes \_\_\_\_No If yes, how often? \_\_\_\_\_\_\_\_

Do you use drugs? (marijuana, cocaine etc.) \_\_\_\_ Yes \_\_\_\_No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mf 01/18/2019

**Patient Screening:**

Do you receive you Flu Vaccine in 2018 in a location other then our office? \_\_\_\_\_\_\_\_\_\_

Date of last Osteoporosis Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Mammogram: \_\_\_\_\_\_\_\_\_\_\_

Date of last Colon Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Cervical Cancer (PAP) Screening: \_\_\_\_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_ Name of eye care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Dental Exam; \_\_\_\_\_\_\_\_\_\_

For Diabetic Patients – Date of last Diabetic Foot exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medication, X-Ray Dyes, or other Substance \_\_\_\_\_Yes \_\_\_\_No

(if yes, please list what you are allergic to and reaction)

Allergy Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History: Has any member of your family (including parents, grandparents, siblings) ever had the following?

Cancer \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Hypertension \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Heart Disease \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Diabetes \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Strokes \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Glaucoma \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Mental Disorders \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Anxiety \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Depression \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Drug Addiction \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Alcohol Addiction \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Bleeding Disorders \_\_\_ Mother \_\_\_\_Father \_\_\_\_ Grandmother \_\_\_\_Grandfather \_\_\_ Sibling

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries: Please list any surgeries you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you have a “Living Will” \_\_\_ Yes \_\_\_ No**

**Medical Power of Attorney? \_\_\_ Yes \_\_\_ No**

**Do we have a copy of LW and POA? \_\_\_ Yes \_\_\_ No**

**If no would you like to make an appointment to discuss? \_\_\_\_Yes \_\_\_No**

**Would you like information for “Looking Ahead” and advance healthcare planning – a partner with Doylestown Health**