Story Family Medicine

Existing Patient Medical Health Review

Today's Date:____________

Name:______________________________ Date of Birth_________ Primary Home Cell____________________
Email:______________________________ (Mailing Address):______________________________
City State Zip

Health Insurance Information

Has your Health Insurance Plan changed? Yes No (If yes, please provide us with your new Insurance cards)

In Case of an Emergency

Name:____________________ Relationship Spouse Parent Grandparent Friend Other:__________
Phone:________________ Are we able to disclose Medical Information with them? Yes No

Advanced Care Directives, Medical Wishes or Other Preferences

Do you have a Living Will? Yes No
Are you an Organ Donor? Yes No
Do you have a DNR? Yes No

Do you have a Power of Attorney/Health Care Surrogate? Yes No
Name____________________ Phone: __________________

Health and Social History

Have you ever smoked/used tobacco products? Yes No (If Former smoker, when did you Quit?)______
Do you currently smoke? Yes No (If you currently smoke, how many a day or week?) _________
Do you drink alcohol? Yes No (If yes, how often): ______ Currently use recreational drugs? Yes No
Do exercise regularly? Yes No (If yes, how often): _________ What type of exercise?_____________
Nutritional Diets: Diabetic Diet Low Sodium Low Fat Low Cholesterol Other: ____________
Do you have drug, environment or food allergies? Yes No(If yes, please list type and reactions)
____
Do you currently work? Yes No Are you Retired? Yes No Are you currently Disabled? Yes No

Major Events Review

Any Emergency Care/Surgeries or Hospitalizations in the last 90 days? Yes No(Please List Type/Date/Reason)
____

General Health Update and Medical History

Do you have any current health concerns that need further clarification? Yes No (If yes, please explain)
____

Family History

	Mother	Father	Sibling	Other
Alcoholism				__________
Cancer				__________
Depression				__________
Diabetes				__________
Heart Disease				__________
Heart Issues				__________
Hypertension				__________

Procedures or Testing (List the Year Completed)

Diagnostic Tests:
- Colonoscopy: _______
- Bone Density: _______
- Mammogram: _______
- Chest Xray: _______
- Chest CT: _______
- EKG: _______
- ECHO: _______
- Stress Test: _______
- AAA U/S: _______
- Other: __________

- Last Labs: _______
- Eye Exam: ________
- Foot Exam: _______
- Pap/Breast Exam: ______
- Prostate Exam: _______

Adult Immunizations:
- Flu: _______
- Pneumonia 23: ______
- Prevnar 13 (Booster):______
- TDap: ______
- MMR: ______
- Zoster (Shingles):______
- Hep A:______ Hep B:______

Review of Symptoms or New Complaints

Head & Neck:
Headaches
Dizziness
Lightheaded
Memory Loss

Eyes:
Blurred Vision
Eye Pain
Worsening Sight

Oral:
Dry Mouth
Loss of Taste

Ears and Hearing:
Hearing Loss
Ringing in Ears
Wax Buildup

Nose & Throat:
Sneezing
Nose Bleeds
Runny Nose
Sinus Issues
Sore Throat

Respiratory:
Cough
Shortness of Breath
Wheezing

Cardiac:
Chest Pain
Blood Pressure
Palpitations

General Mood:
Anxiety
Depression
Mood Changes

Muscle/Joints:
Back Pain
Sore Muscles
Painful Joints
Foot Pain
Leg Pain

Urinary:
Burning
Frequency
Incontinence
Hesitancy

Neurological:
Confusion
Dizziness
Seizures
Numbness
Tingling
Tremors/Shaking
Poor Balance
Poor Coordination

Skin:
Rash/Hives
Itching
Bruising
Abnormal Growth