**Medical History and Social History** 

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**What is the reason for your appointment today?**

**Allergies To Medications? What was the reaction?:**

**Please list ALL MEDICATIONS you are taking (including herbal remedies and over the counter medications):**

**Please indicate all surgeries you have had (with approximate year of the surgery):**

|  |  |  |  |
| --- | --- | --- | --- |
| Aortic Aneurysm | Cataract Surgery /Eye Surgery | Heart Surgery | Heart Angioplasty |
| Appendix | Cholecystectomy / Gallbladder | Hernia Repair | Thyroid Surgery |
| Back Surgery or Neck Surgery | Colon Resection | Hip or Knee Replacement | Tonsillectomy |
| C-Section | Coronary Artery Bypass | Hysterectomy | Weight Loss Surgery |
| Mastectomy / Breast Cancer Surgery | Heart Pacemaker | Hemorrhoid Surgery | Radiation treatment? |

**Other Surgeries Not Listed Above:**

**Circle all medical problems for which you see a doctor regularly (diabetes, hypertension, etc.):**

|  |  |  |  |
| --- | --- | --- | --- |
| Anxiety or Depression | Colon Cancer | Diabetes | Hypercholesterolemia/High Cholesterol |
| Arthritis | Congestive Heart Failure | Diverticulosis | High Blood Pressure /Hypertension |
| Asthma | Constipation | Fibromyalgia | Heart Disease |
| Breast Cancer | COPD | GERD / reflux | Peripheral Vascular Disease |
| Stroke / TIA | Crohn’s Disease | Glaucoma |  |
| Chest Pain / Angina | Dementia | Gout | Sleep Apnea |

**Other Medical Problems Not Listed Above:**

**Does anyone in your family (besides you) have a history of:**

|  |  |  |  |
| --- | --- | --- | --- |
| Prostate Cancer | Kidney Cancer | Bladder Cancer | Kidney Stones |

**Family History of Other Diseases:**

**Marital Status**:

[ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ]  Separated

**Smoking Status**:

 [ ] Current every day smoker [ ] Current some day smoker [ ] Former smoker [ ] Never smoker

**Race** (not mandatory, requested by government)

[ ] American Indian/Alaska Native [ ] Black/African American [ ] Hawaiian/Pacific Islander [ ] White

[ ] Asian [ ] Decline to state

**Ethnicity** (not mandatory, requested by government)

[ ]  Not Hispanic or Latino [ ]  Hispanic or Latino [ ]  Decline to state

**Preferred language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following?**

|  |  |  |
| --- | --- | --- |
| Fever | Chills | Weight Loss |
| Blurry vision | Double Vision | Cataracts |
| Hearing Loss | Nasal Stuffiness | Sore Throat |
| Chest Pains | Swollen Ankles | Irregular Heartbeat |
| Shortness of Breath | Wheezing | Chronic Cough |
| Abdominal Pain | Nausea/Vomiting | Change in Bowels |
| Incontinence | Painful Urination | Blood in Urine |
| Chronic Back Pain | Chronic Neck Pain | Sore Muscles |
| Rash | Persistent itching | Skin Cancer History |
| Numbness | Tingling | Dizziness |
| Swollen Glands | Abnormal Bleeding | Transfusion History |

**How much do you weigh?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your typical blood pressure** (if known)? \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

**How tall are you?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your primary care Doctor?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What and where is your preferred pharmacy?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street (do not need address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_