Journey
Family Medicine

Medical History Form

Name (First, Last): _____ Date of Birth: _____

Other medical providers involved in my care: _____

What areas or issues would you like to discuss today? (Please limit to two items) _____

_____

Current Medications (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs, etc.)

***Please bring your medication bottles to your office visit.**

Medication	Dose	Time/Day

Drug Allergies

Medication	Type of Reaction

Personal Medical History

Have you been diagnosed with any of the following conditions?

HEART/VASCULAR DISEASE:

- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Abdominal Aortic Aneurysm
- ☐ Congestive Heart Failure
- ☐ Aortic Valve Disorder
- ☐ Atrial Fibrillation
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Peripheral Vascular Disease
- ☐ Heart Valve Condition
- ☐ Other
- ☐ None of the Above

KIDNEY/BLADDER

- ☐ Benign Prostate Hypertrophy
- ☐ Erectile Dysfunction
- ☐ Chronic Kidney Disease
- ☐ Hypogonadism
- ☐ Urinary - Incontinence
- ☐ Kidney Stones
- ☐ PSA – Elevated
- ☐ Other
- ☐ None of the Above

CANCER:

- ☐ Breast Cancer
- ☐ Lung Cancer
- ☐ Colon Cancer
- ☐ Skin Cancer
- ☐ Prostate Cancer
- ☐ Other _____
- ☐ None of the Above

MENTAL HEALTH/ NEUROLOGIC:

- ☐ Depression
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Migraine
- ☐ Neuropathy
- ☐ ADHD
- ☐ Stroke
- ☐ None of the Above

METABOLIC/NUTRITION:

- ☐ Diabetes
- ☐ Anemia
- ☐ Thyroid Disorder
- ☐ Impaired Fasting Glucose
- ☐ Eating Disorder
- ☐ Other
- ☐ None of the Above

MUSCULOSKELETAL:

- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other
- ☐ None of the Above

GYNECOLOGICAL:

- ☐ Pap Abnormal
- ☐ Ovarian Cyst
- ☐ Other
- ☐ None of the Above

RESPIRATORY

- ☐ Asthma
- ☐ Allergies
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Sleep Apnea
- ☐ Other
- ☐ None of the Above

GASTROINTESTINAL:

- ☐ Peptic Ulcers
- ☐ Hepatitis, Type _____
- ☐ GERD
- ☐ IBS
- ☐ Other
- ☐ None of the Above

INFECTIOUSDISEASE:

_____

_____

_____

_____

Surgical History

What surgeries have you received? (Please list year that specified surgery was performed)

Surgery	Year

Other hospitalizations and serious illnesses or injuries: (omit pregnancies)

Hospitalization, Illness or Injury	Date

Social History

Occupation: _____ Pronouns: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No

If yes, what are their dates of birth? _____

Who lives at home with you? _____

Do you exercise? ☐ Yes ☐ No If yes, what type of exercise? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many servings of alcohol per day? _____

Do you use caffeine? ☐ Yes ☐ No If yes, how many servings of caffeine per day? _____

Do you smoke tobacco? ☐ Never ☐ Current ☐ Former

How much tobacco do you smoke? _____ What year did you quit? _____

Do you use smokeless tobacco? ☐ Never ☐ Current ☐ Former

How much smokeless tobacco do you use? _____ What year did you quit? _____

Do you use cigars or pipes? ☐ Never ☐ Current ☐ Former

How much do you use cigars or pipes? _____ What year did you quit? _____

Do you have passive smoke exposure? ☐ Yes ☐ No

Do you use drugs? ☐ Never ☐ Current ☐ Former

What drugs? _____ What year did you quit? _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, what year? _____

Family History (Indicate which relative has had the following diseases, the age of onset and time of death if deceased.)

Disease	Family Members	Age of Onset & Death
Heart Disease		
Depression		

Disease	Family Members	Age of Onset & Death
Hypertension		
Alcoholism		
ADHD		
Asthma		
Autism		
Cancer		
Celiac Disease		
COPD		
Bleeding Disorders		
Anemia		
Anxiety		
CVA/Stroke		
Dementia		
Thyroid Disorder		
Headaches		
Growth/Development Disorder		
Liver Disease		
Osteoporosis		
Peptic Ulcer Disease		
Respiratory Disease		
Seizure Disorder		
Substance Abuse		
Arthritis		
Diabetes		

Review of Systems

Check any of the following symptoms you have experienced WITHIN THE PAST YEAR.

GENERAL:

- ☐ Change in Heat & Cold Tolerance
- ☐ Persistent Fever
- ☐ Appetite Change
- ☐ Night Sweats
- ☐ Swollen Glands
- ☐ Fatigue
- ☐ Weight Change
- ☐ None of the Above

URINARY:

- ☐ Change in Urinary Stream
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Leaking Urine
- ☐ Pain or Burning on Urination
- ☐ Up at Night to Urinate
- ☐ Sexual Difficulty
- ☐ Other
- ☐ None of the Above

MOOD/MENTALHEALTH:

- ☐ Depressed or Sad
- ☐ Irritable or Angry
- ☐ Anxious
- ☐ Sleep Problems
- ☐ Fatigue
- ☐ Suicidal Thoughts
- ☐ Concentration/Memory Problems
- ☐ Marital, Family or Work Problems
- ☐ None of the Above

EARS/NOSE/THROAT:

- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing In Ears
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Neck Swelling/Lumps
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Other
- ☐ None of the Above

GASTROINTESTINAL:

- ☐ Bloody or Black Stools
- ☐ Change in Stools
- ☐ Difficult Swallowing
- ☐ Food Intolerance
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Other
- ☐ None of the Above

SKIN:

- ☐ Change in Skin or Mole
- ☐ Rash or Hives
- ☐ Nail Change
- ☐ Unusual Hair Loss
- ☐ Other
- ☐ None of the Above

BONES AND JOINTS:

- ☐ Back or Neck Pain
- ☐ Cramps in Muscles
- ☐ Painful or Stiff Joints
- ☐ Swelling in Legs
- ☐ Redness of Joints
- ☐ Other
- ☐ None of the Above

BREASTS:

- ☐ Rash of Breast
- ☐ Lump
- ☐ Pain
- ☐ Other
- ☐ Not Applicable
- ☐ None of the Above

LUNGS:

- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Wheezing
- ☐ Cough Up Blood
- ☐ Other
- ☐ None of the Above

FEMALE:

- ☐ Heavy Menstrual Bleeding
- ☐ Irregular Menstrual Periods
- ☐ Vaginal Discharge
- ☐ PMS
- ☐ Other
- ☐ Not Applicable
- ☐ None of the Above

EYES:

- ☐ Change in Vision
- ☐ Contact Lenses
- ☐ Other
- ☐ None of the Above

HEART:

- ☐ Chest Discomfort/Pain
- ☐ Irregular Heart Beat
- ☐ Racing or Fluttering Heart
- ☐ Swollen Feet or Ankles
- ☐ Varicose Veins
- ☐ Other
- ☐ None of the Above

NEUROLOGIC:

- ☐ Coordination Problems
- ☐ Difficulties in Speaking
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Muscle Weakness
- ☐ Numbness or Tingling
- ☐ Other
- ☐ None of the Above

ALLERGY:

- ☐ Sneezing
- ☐ Environmental Allergy
- ☐ Food Allergy
- ☐ Other
- ☐ None of the Above

Signature: _____ Date: _____