Journey
Family Medicine

Medical History Form

Full Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: _____ Pronouns: _____

Other medical providers involved in my care: _____

What would you like to discuss today? (Please limit to two items.) _____

_____

_____

_____

Current Medications (Please note, we do not routinely prescribe most long-term, controlled medications.)

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

Medication	Dose	Times Per Day

Preferred Pharmacy: _____

Drug Allergies

Medication	Type of Reaction

Surgical History

Surgery	Year Performed

Hospitalizations

Illness or Injury	Date(s)

Personal Medical History
Have you been diagnosed with any of the following conditions?

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

GASTROINTESTINAL
- ☐ Gastroesophageal Reflux Disease
- ☐ Hepatitis, Type _____
- ☐ IBS
- ☐ Peptic Ulcers
- ☐ Other _____
- ☐ **None of the Above**

GYNECOLOGY
- ☐ Abnormal Pap Smear
- ☐ Ovarian Cyst
- ☐ Other _____
- ☐ **None of the Above**

HEART/VESSELS
- ☐ Abdominal Aortic Aneurysm
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis/Pulmonary Embolism
- ☐ Heart Attack
- ☐ Heart Valve Condition
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Peripheral Vascular Disease
- ☐ Other _____
- ☐ **None of the Above**

KIDNEY/BLADDER
- ☐ Benign Prostate Hypertrophy
- ☐ Chronic Kidney Disease
- ☐ Elevated PSA
- ☐ Erectile Dysfunction
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Other _____
- ☐ **None of the Above**

MENTAL HEALTH/ NEUROLOGIC
- ☐ ADHD
- ☐ Alcohol/Substance Use Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Migraine/Headache
- ☐ Neuropathy
- ☐ Stroke/TIA
- ☐ Other _____
- ☐ **None of the Above**

METABOLIC/NUTRITION
- ☐ Anemia
- ☐ Diabetes/Prediabetes/Gestational Diabetes
- ☐ Eating Disorder
- ☐ Thyroid Disorder
- ☐ Other _____
- ☐ **None of the Above**

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteopenia/Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Other _____
- ☐ **None of the Above**

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

Social History

Occupation: _____

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

Do you have children? ☐ Yes ☐ No If yes, what are their dates of birth? _____

Who do you live with? _____ Do you feel safe at home? _____

Do you get physical activity? ☐ Yes ☐ No Type/frequency? _____

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

Tobacco Use:

☐ **Former**	☐ **Current**	☐ **Never**
Type: ☐ Cigarettes ☐ Vape ☐ Smokeless tobacco ☐ Cigars or pipes	Type: ☐ Cigarettes ☐ Vape ☐ Smokeless tobacco ☐ Cigars or pipes	
How much per day?	How much per day?	
Age when you started:	Age when you started:	
Year quit:		

Do you have passive smoke exposure? ☐ Yes ☐ No

Alcohol Use:

☐ **Former**	☐ **Current**	☐ **Never**
How many drinks per day?	How many drinks per day?	
Year quit:		

Cannabis Use:

☐ **Former**	☐ **Current**	☐ **Never**
What type?	What type?	
How often?	How often?	
Last use:		

Illicit Drug Use:

☐ **Former**	☐ **Current**	☐ **Never**
What type?	What type?	
How often?	How often?	
Last use:		

Family History

Disease	Family member(s)	Age of onset	If deceased, age of death
Alcohol/Substance Use Disorder			
Bleeding/Clotting Disorder			
Cancer			
Dementia			
Diabetes			
Gastrointestinal Disease			
Growth/Development Disorder			
Heart Disease/Heart Attack			
High Cholesterol			
Hypertension			
Liver Disease			
Migraine Headache			
Osteoporosis			
Respiratory Disease			
Seizure Disorder			
Stroke			
Thyroid Disorder			
Other			

Review of Systems

Check any of the following concerns or symptoms you have experienced **in the past month.**

GENERAL
- ☐ Appetite Change
- ☐ Change in Heat or Cold Tolerance
- ☐ Fever or Chills
- ☐ Night Sweats or Hot Flashes
- ☐ Recurrent Infections
- ☐ Swollen Glands
- ☐ Unusual Fatigue
- ☐ Weight Loss _____
- ☐ Weight Gain _____
- ☐ Other _____
- ☐ **None of the Above**

MENTAL HEALTH
- ☐ Anxiety
- ☐ Concentration or Memory Issues
- ☐ Concern About Substance Use
- ☐ Depressed Mood
- ☐ Marital, Family or Work Issues
- ☐ Sleep Problems
- ☐ Suicidal Thoughts
- ☐ Other _____
- ☐ **None of the Above**

MUSCULOSKELETAL
- ☐ Back or Neck Pain
- ☐ Painful or Stiff Joints
- ☐ Red or Swollen Joints
- ☐ Other _____
- ☐ **None of the Above**

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

EYES
- ☐ Change in Vision
- ☐ Contact Lenses
- ☐ Eye Pain
- ☐ Other _____
- ☐ **None of the Above**

EARS/NOSE/THROAT
- ☐ Bleeding Gums
- ☐ Earache
- ☐ Environmental Allergy
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Neck Swelling
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Sinus Pain
- ☐ Other _____
- ☐ **None of the Above**

BREASTS
- ☐ Breastfeeding
- ☐ Lump
- ☐ Nipple Discharge
- ☐ Pain
- ☐ Rash of Breast
- ☐ Other _____
- ☐ **None of the Above**

LUNGS
- ☐ Cough up Blood
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other _____
- ☐ **None of the Above**

HEART
- ☐ Chest Discomfort or Pain
- ☐ Excessive Bleeding or Bruising
- ☐ Irregular Heart Beat
- ☐ Racing or Fluttering Heart
- ☐ Swollen Feet or Ankles
- ☐ Varicose Veins
- ☐ Other _____
- ☐ **None of the Above**

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Bloody or Black Stools
- ☐ Change in Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Swallowing
- ☐ Food Allergy
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Vomiting or Nausea
- ☐ Other _____
- ☐ **None of the Above**

GENITAL/URINARY
- ☐ Blood in Urine
- ☐ Change in Urinary Stream
- ☐ Frequent Urination
- ☐ Heavy Menstrual Bleeding
- ☐ Irregular Menstrual Periods
- ☐ Leaking Urine
- ☐ Pain or Burning with Urination
- ☐ Pelvic Pain
- ☐ PMS
- ☐ Sexual Concerns
- ☐ Up at Night to Urinate
- ☐ Vaginal or Penile Discharge
- ☐ Other _____
- ☐ **None of the Above**

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

Signature: _____ Date: _____