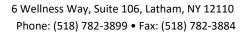


## **Medical History Form**

Patient Name:				DOB:		Date:	
Reason for Visit:							
Medication List: Please list all medications, on Name: e.g., Folic Acid			over the counter drugs and supplements you are concern the counter drugs are concern to the counter drugs and supplements you are concern to the counter drugs are concern to the			urrently taking. ructions: e.g., 1 tab daily	
			_				
Allergy List: Please list all t Name: e.g., penicillin	hings y	ou are alle	rgic to and how it a Reaction: e.g., Hiv				
Past Medical History:	Self	Family N	1ember		Self	Family Member	
	0	-		Stroke	0	<del></del>	
Lupus	$\bigcirc$			COPD	$\bigcirc$		
Psoriatic Arthritis	$\bigcirc$			Asthma	$\bigcirc$		
Ankylosing Spondylitis	$\bigcirc$			Diabetes	$\circ$		
Uveitis/Scleritis	$\circ$			Chronic Kidney Dis	ease 🔘		
Crohn's/Ulcerative Colitis	$\bigcirc$			GERD	0		
Sjogren's Syndrome	0			Stomach Ulcers	$\bigcirc$		
Scleroderma	0			Hypothyroidism	0		
	0			Cancer	0		
Psoriasis	$\bigcirc$			Anemia	O		
Osteoporosis/Osteopenia	0			Prostate	0		
Gout	$\bigcirc$			Macular Degenera			
Osteoarthritis	$\bigcirc$			Glaucoma	0		
Coronary Artery Disease	$\bigcirc$			Depression	O		
High Cholesterol	$\bigcirc$			Anxiety	O		
High Blood Pressure	0			Seizures	0		
J	$\bigcirc$			Lung Clot/DVT	$\circ$		
Other Major Illness:							
Surgical History: Please lis	t all pas	t operatio	ns with dates				





**Social History:** Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: () Male () Female	Marital Status: ○ Single ○ Marr	fied $\bigcirc$ Divorced $\bigcirc$ Widow $\bigcirc$ O	ther:	
Primary Language:   English (	French Spanish Other:	Occupation:		
Number of Pregnancies:	Number of Children:	Numbe	er of Miscarriages:	
Tobacco Use:   Never smoked	Currently smoke (# packs per day)	OI have quit smoking (	age when stopped)	
Alcohol Use: How many days pe	er week to you drink? # of drink	s per day? Have you ever had	d a problem with alcohol?	
Recreational Drug Use: Do you u	ise drugs? Yes No How often?	Have you ever had a pro	oblem with illicit drugs?	
Pharmacy:				
Retail:	Address:	Phone:		
	Address:			
Mail Order:	Address:	Phone:		
Names of Physicians/Other Spec	cialists which are treating you:			
	Phone:	Specialty:		
	Phone:			
	Phone:			
	Phone:			
In the past month, have you experience □ Weight change	erienced any of the following? Check    Palpitations	box if yes.  □ Sinus pain	□ Abdominal pain	
□ Chills	□ Rash	□ Eyes itch	□ Diarrhea	
□ Fever	☐ Skin lesion	□ Earache	☐ Black or tarry stools	
□ Night sweats	□ Itching	□ Loss of hearing	□ Constipation	
☐ Feeling tired or poorly	☐ White or purple fingers or	□ Ringing in ears	□ Joint pain	
□ Headache	toes	□ Nosebleeds	☐ Joint stiffness	
□ Facial pain	□ Pain during urination	□ Nasal discharge	□ Joint swelling	
□ Sinus pain	□ Urinary frequency	□ Mouth sores	☐ Muscle aches	
☐ Head-related symptoms	☐ Blood in urine	□ Bleeding gums	□ Back pain	
□ Easy bleeding	□ Genital lesion	□ Hoarseness	☐ Muscle weakness	
□ Easy bruising	□ Vaginal discharge	□ Sore throat	□ Dizziness	
□ Neck pain	☐ Pain during intercourse	☐ Shortness of breath	□ Fainting	
☐ Lump or swelling in the	□ Incontinence	□ Cough	□ Motor disturbances	
neck	□ Excessive sweating	□ Wheezing	□ Sensory disturbances	
□ Breast pain	☐ Excessive thirst	□ Poor appetite	☐ Sleep disturbance	
□ Nipple discharge	☐ Hot flashes	□ Difficulty swallowing	□ Anxiety	
☐ Breast lump	☐ Decrease in height	□ Heartburn	□ Depression	
☐ Chest pain	☐ Vision problems	□ Nausea		
□ Pounding heartbeat	☐ Eye sensitivity	□ Vomiting		