Nourish Wellness Family Medicine, LLC

COMPLETE PATIENT MEDICAL HISTORY

YOUR NAME:_____SEX DATE OF BIRTH_____

REASON FOR VISIT

What problems are you seeing the doctor for today? (Please list all problems, how long, and how often they have troubled you.)

_____

_____

_____

_____

PRIOR MEDICAL HISTORY

PAST/CURRENT CONDITIONS
Have you ever had any of these problems?

—Anemia
__Bleeding
__Blood Clots
__Blood Transfusion
__Diabetes
—Thyroid Problems
—Fainting
—Seizure
—Fever or infections
— Glaucoma
—Cataracts
—Asthma
—Pneumonia
— Emphysema
—Tuberculosis
__Cancer
—High Blood Pressure
—Heart Attack
—Heart Rhythm Problem
__Blood Vessel Surgery
—Heart Failure
—Heart Valve Problem
—Hiatal Hernia
__Ulcers
—Hepatitis
—Jaundice
—Gall Stones
__Diarrhea
— Depression
—Rectal Bleeding
__Kidney Stones
__Kidney Infection
—Kidney Failure
—Prostate Problems
—Stroke
— Epilepsy
—Veneral Diseases
—Back Pain
—Neck Pain
—Gout
—Arthritis
—Menstrual Problems
—Loss of urine or stool
—Other: Pleas list below.

_____
_____
_____
_____

PAST OPERATIONS
FEMALE HISTORY

Type of Operation	Date of Operation	Doctor or Hospital

When did your periods begin?_____How often are your periods?_____

Have you stopped having regular periods?_____When?_____

Do you consider your periods normal?_____

Have you ever been pregnant? How many times have you been pregnant?_____

How many children have you delivered?_____

PAST FAMILY HISTORY

List the ages and health problems of the people listed. If they are no longer living, what did they die from?

FATHER_____

MOTHER _____

BROTHERS AND SISTERS _____

_____

SPOUSE_____

CHILDREN _____

Does anyone in your family have these problems?

—Heart Problems —Prostate Cancer

___Breast Cancer ------Skin Cancer

——— Colon Cancer ——— Diabetes

SOCIAL HISTORY

What is your occupation? _____

Do you have hobbies? _____

Have you ever smoked?_____How much?_____How Long?_____

Do you have smoke detectors in your house?_____Do you wear a seat belt?_____

Do you drink any alcohol (beer, wine, liquor)? How much? _____

Have you ever used illegal drugs? _____

Have you ever had a family member hurt you? _____

If you are married, do you have a happy marriage?_____

Have you ever had a sexually related disease like Aids or Gonorrhea? _____

Do you exercise regularly?_____

ALLERGIES TO MEDICATIONS AND FOOD

What medicines, foods, plants or insects are you allergic to?

Allergy	Your Reaction	Allergy	Your Reaction

MEDICINES YOU TAKE

List all medicines you take. This includes medicines from a doctor and medicines you buy yourself at a store.

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

Medicine _____ Dosage _____

PRIOR SHOTS AND TESTS

	Date		Date
__Tetanus Shot	_____	__Pap Smear	_____
__Flu Shot	_____	__Mammogram	_____
__Pneumonia Shot	_____	__Hepatitis Shot	_____
__Cholesterol Level	_____		

REVIEW OF PROBLEMS

Do you have any of the following problems?

Weight gain or loss_____
Tiredness_____
Sadness_____
Not Sleeping_____
Dizziness_____
Headaches_____
Eye or Ear Problems_____
Nose or Sinus Problems_____
Breast Problems_____
Chest Pain_____
Breathing Problems_____

Heartburn_____
Stomach Pain_____
Nausea_____
Diarrhea or Constipation_____
Knee or Hip Pain_____
Tingling_____
Urination Problems_____
Abnormal Periods_____
Gonorrhea or Chlamydia_____
Cough_____

OTHER COMMENTS

Do you have any other comments for the doctor or nurse?

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature_____ Date_____
Physician Reviewed_____ Date_____