Athens Regional Physicians Services/Hawthorne Medical Associates - Medical History Form

(Revised 4-2013)

First Name:	MI:	Last Name:	Preferred Name:
Date of Birth:	Age:	Today's Date:	Who referred you to our practice?

Other Physicians and Healthcare Providers:

What other doctors do you see? What other health care providers or companies do you use?
If they are not in the Athens area, please give their location and phone numbers. (Attach a list if needed)

Allergies (please list):	**Preventive Reminders:**	**Local Pharmacy Name & Location:**
Medications:	Preferred notification method:	Phone number:
Food:	(_) Postal mail (default)	
	(_) Telephone	**Mail order Pharmacy Information:**
Other:	(_) Web message	Fax #

Immunizations: Please give dates - your best guess is ok

Tetanus shot:	Hepatitis B #1	Zostavax (shingles)
Pneumonia shot:	Hepatitis B #2	Other:
Flu shot:	Hepatitis B #3	Other:

Family MEDICAL History: (please list any medical problems, past or present)

Father: (___) Living (___) Deceased at age _____ Medical Problems:

Mother: (___) Living (___) Deceased at age _____ Medical Problems:

Brothers: # of brothers: _____ Medical Problems:

Sisters: # of sisters: _____ Medical Problems:

Children: # of children: _____ Medical Problems:

Chronic Diseases: (please check any you have)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots (DVT/PE)
- ☐ Cancer:
- ☐ Colon polyps
- ☐ Congestive heart failure
- ☐ COPD (pulmonary disease)
- ☐ Coronary artery disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Emphysema
- ☐ Fibrocystic breast disease
- ☐ Fibromyalgia
- ☐ GERD (reflux disease)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart problems
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel syndrome
- ☐ Kidney stones
- ☐ Macular degeneration
- ☐ Menopausal symptoms
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Prostate problems
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid problems

Other:

Your name: (we need your name on every page) **Page 2 MHF**

Surgeries: (List DATES and DOCTORS)

Preventive Health Services: (please list the DATE of your most recent test)

Mammogram:	Bone density test:	Colonoscopy:
Pap Smear:	Prostate blood test (PSA):	Rectal exam:
DIABETICS:	Date of last dilated eye exam:	Date of last foot exam:
	Name of eye doctor:	Name of foot doctor:

Social History:

Tobacco: Do you use tobacco? (_) yes (_) no (_) stopped When started? _____ When stopped? _____
What form of tobacco do/did you use? (_) cigarettes (_) cigars (_) pipe (_) dip (_) chew (_) snuff
Would you be interested in quitting tobacco in the next month? (_) Yes (_) No

Alcohol: Do you use alcohol? (_) yes (_) no Describe:

Recreational Drugs: Do you use recreational drugs? (_) yes (_) no (_) stopped. Describe:

Exercise: Do you exercise? (_) yes (_) no
In the past 7 days, how many days did you exercise? _____
On the days you exercised, for how long did you exercise? _____ minutes
How intense was your typical exercise? (choose one)

☐ Light (like stretching or slow walking)	☐ Heavy (like jogging or swimming)
☐ Moderate (like brisk walking)	☐ Very heavy (like fast running or stairs)

State or country of birth:	Education: (highest degree in school)	Occupation: (before retirement)
Do you use seat belts? (_) yes (_) no	Marital Status: (_) single (_) married (_) separated (_) divorced (_) widowed	Hobbies:

Do you have a living will? (_) yes (_) no. If yes, please bring in a copy.
Do you have a durable power of attorney? (_) yes (_) no. If yes, please bring in a copy.

Travel history: Have you traveled out of the country in the past five (5) years? If yes, when and where:

Nutrition: (please answer about the past seven (7) days:
How many servings of fruits and vegetables did you typically eat each day? _____
(1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables or 1 medium piece of fruit. 1 cup = size of a baseball.

How many servings of high fiber or whole grain foods did you typically eat each day? _____
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal, or 1/2 cup of cooked brown rice or whole wheat pasta).

How many servings of fried or high fat foods did you typically eat each day? _____
(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, donuts, creamy salad dressings and foods made with whole milk, cheese or mayonnaise).

How many sugar-sweetened (not diet) beverages did you typically consume each day? _____

Medications:

Please list (or attach a list) of the medications you currently take. We need to know the STRENGTH and HOW OFTEN you take it. Include over-the-counter medicines and vitamins.

Review of Systems: Answer YES for any of your concerns. Please answer all questions.

(For office use: Problem pertinent=1 system, Extended=2-9 systems, Complete=10 systems

GENERAL:			**DIABETES:**			**HEMATOLOGY:**		
Fatigue	Yes	No	Sugars controlled	Yes	No	Anemia	Yes	No
Weight gain > 10 lbs	Yes	No	Visual problems	Yes	No	Enlarged lymph nodes	Yes	No
Weight loss > 10 lbs	Yes	No	Foot numbness/tingling	Yes	No	**MALE GENITOURINARY:**		
SKIN:			Foot sores	Yes	No	Blood in urine	Yes	No
New spots or lesions	Yes	No	**CARDIOVASCULAR:**			Erection problem	Yes	No
Itching (pruritus)	Yes	No	Chest pain	Yes	No	Nighttime urination	Yes	No
Rash	Yes	No	Swelling in arms/legs	Yes	No	Change in urinary stream	Yes	No
HEENT:			Palpitations	Yes	No	**FEMALE GENITOURINARY:**		
Decreased hearing	Yes	No	**GASTROINTESTINAL:**			Painful urination	Yes	No
Ringing in ears (tinnitus)	Yes	No	Abdominal pain	Yes	No	Blood in urine	Yes	No
NECK:			Change in bowel habits	Yes	No	Vaginal discharge	Yes	No
Neck pain	Yes	No	Constipation	Yes	No	**NEUROLOGICAL:**		
Swollen glands	Yes	No	Heartburn	Yes	No	Headache	Yes	No
RESPIRATORY:			Rectal bleeding	Yes	No	Seizures	Yes	No
Cough	Yes	No	**MUSCULOSKELETAL:**			Dizziness	Yes	No
Shortness of breath	Yes	No	Joint pain	Yes	No			
Wheezing	Yes	No	Joint swelling	Yes	No	Insomnia	Yes	No
BREAST:			Back pain	Yes	No	Anxiety	Yes	No
Breast mass	Yes	No	**ENDOCRINE:**			Depression	Yes	No
Breast pain	Yes	No	Appetite changes	Yes	No			

OTHER: (please list)

How likely are you to doze off or fall asleep during the following situations?

Use the following scale:

0 = would never doze off
1 = slight chance of dozing off
2 = moderate chance of dozing off
3 = high chance of dozing off

_____ Sitting and reading
_____ Watching TV
_____ Sitting, inactive in a public place
_____ As a passenger in a car for an hour
_____ Lying down in the afternoon
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

Total score: