Houston Family & Geriatric Medicine

Patient Medical History Form

Name: _____ AGE:_____ Date:_____

Physician you were seeing previously: _____

Other SPECIALISTS you currently see _____

_____

MEDICAL PROBELMS (including present conditions): _____

_____

List all CURRENT PRESCRIPTION MEDICINES (including dosage, reason for taking, who prescribed)_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins and food supplements that you take:_____

_____

_____

ALLERGIES to MEDICATIONS (including reactions) _____

_____

List SURGERIES you have had (include year, surgeon, and hospital): _____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital):_____

_____

_____

Have you had:

☐Migraines	☐Hepatitis	☐Mono	☐Ulcer	☐Bleeding problem
☐Blood clots	☐Head injury	☐Drug addiction	☐Tuberculosis	☐Psoriasis
☐Alcoholism	☐Hearing trouble	☐Vision trouble	☐Depression	☐Heart murmur
☐STDs	☐Seizures	☐Rheumatic fever	☐Mental illness	☐Memory loss
☐Polio	☐Gout	☐Arthritis	☐Gallstone	☐Shingles
☐Hemorrhoids	☐Other _____	☐Other _____	☐Other _____	☐Other _____

Do you have a Living Will?☐Yes ☐No If not, are you interested in having one? ☐Yes ☐No

Do/did you SMOKE?☐Yes☐No How Much (packs/day)? _____ # of years _____ Year you QUIT _____

When was the last time you tried to QUIT? _____ How many times have you tried? _____

How have you been successful in quitting in the past? _____

Do/did you DRINK alcohol? ☐Yes ☐No How much (Drinks/week)? _____ # of years _____

Year you QUIT _____ Previous or current problems with alcohol?_____ AA?_____

Do/did you use: ☐heroin ☐marijuana ☐cocaine ☐methamphetamine ☐tobacco ☐diet pills

Any history of prescription drug abuse/addition? ☐Yes☐No If yes, which ones_____

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Phone: 281-493-3681 • Fax: 281-589-1465

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WOMEN

Age at first Period:_____ Date of last normal period:_____ # of pregnancies:_____
# of live births:_____ # of children living with you:_____ # of abortions/miscarriages:_____
Problems with pregnancies : Pre-term labor toxemia diabetes high blood pressure other:_____
Birth Control Method: _____
Date of past PAP _____ Result?_____ Done where?_____
Date of last mammogram: _____ Result?_____ Done where?_____

Do you have:

☐ Irregular periods	☐ Bad menstrual cramps	☐ Heavy periods	☐ Abnormal mammogram	☐ Abnormal PAP smear
☐ Pelvic pain	☐ Infertility	☐ Sexual difficulty	☐ Hot flashes	☐ Vaginal discharge
☐ Vaginal dryness	☐ Vaginal odor	☐ Vaginal itching	☐ PMS	☐ Breast changes

ALL

Who in your family has had (please enter age of death if this was the cause of death)

Heart disease	_____	Genetic disorder	_____
Diabetes	_____	Cancer (type)	_____
Thyroid disease	_____	Alcoholism	_____
Mental illness	_____	Arthritis	_____
Glaucoma	_____	Asthma	_____
Allergies	_____	Stomach problems	_____
Tuberculosis	_____	High blood pressure	_____

List any other disease that run in your family and specify relationship to each family member listed

_____

_____

When was your last:

Tetanus shot	_____	Flu shot	_____	Pneumonia vaccine	_____
Hepatitis vaccine	_____	TB test	_____	Colonoscopy	_____
Chest x-ray	_____	EKG	_____		

Who lives with you? _____

Do you have any children? ____ if yes, list names, ages and any major medical problems _____

_____

Where do/did you work? _____ What line of work?_____

What is last grade of school you finished?_____

Anything else you would like use to know? _____

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