CONFIDENTIAL – DO NOT PHOTOCOPY!

NAVESINK MEDICAL ASSOCIATES

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MEDICAL HISTORY FORM

This form is confidential.

Name: (First) (Last) (Middle)

Date of Birth: Age: Social Security #:

How do you rate your general health? ☐excellent ☐good ☐fair ☐poor

PRESENT HEALTH CONCERNS:

MEDICATIONS: (Include prescription and non-prescription drugs, vitamins, herbs, birth control pills. **Please also include doses**)

ALLERGIES AND REACTIONS TO MEDICATIONS:

PAST MEDICAL HISTORY:

	Yes	No		Yes	No
Alcoholism	☐	☐	Depression	☐	☐
Bleeding disorder	☐	☐	Diabetes	☐	☐
Heart disease/heart attack	☐	☐	Thyroid problems	☐	☐
High blood pressure	☐	☐	Stroke	☐	☐
High cholesterol	☐	☐	Sexually Transmitted Disease	☐	☐

Cancer (specify):

Other problems (specify):

Hospitalizations (include causes and dates):

Operations (include dates):

HEALTH MAINTENANCE (include when was your most recent):

	Date		Date
Cholesterol test		Hepatitis B vaccine	
Dental exam		Mammogram	
Eye exam by eye doctor		Measles vaccine	
Flu shot		Rectal examination	
HIV/AIDS test		Sigmoidoscopy/Colonoscopy	
Pap smear		Tuberculosis skin test (PPD)	
Pneumonia vaccine		Shingles vaccine	
Stool test for blood			

FAMILY HISTORY: Is there any family history of the following? Please indicate who has/had the condition

Alcoholism: _____ Depression: _____
Heart disease/heart attack: _____ High blood pressure: _____
Stroke: _____ Diabetes: _____
High Cholesterol: _____ Thyroid problems: _____
Asthma: _____ Glaucoma: _____
Low blood pressure: _____ Rheumatoid Arthritis: _____
Cancer: breast _____ colon _____ prostate _____
melanoma _____ ovarian _____
Other (please specify): _____

	Living?	Age now/or at death	Major illnesses/cause of death
Mother:			
Father:			
Sister(s): #			
Brother(s): #			

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____
Number of Children: _____ Ages of Children: _____
Who lives at home with you? _____
Do you smoke cigarettes? ☐No ☐Yes Number of cigarettes per day _____
Did you use to smoke cigarettes? ☐No ☐Yes When did you stop smoking? _____
How much alcohol do you drink per day? _____
Do you think you should cut down on the amount of alcohol you drink? _____
Do you use any controlled substances (e.g. Marijuana)? ☐No ☐Yes: _____

REVIEW OF SYMPTOMS: (Place check mark in appropriate squares**)**

Constitutional/Endocrine	Yes	No
Fever/chills/sweats	☐	☐
Unexplained weight loss/gain	☐	☐
Weakness	☐	☐
Loss of energy	☐	☐
Excessive thirst	☐	☐
Excessive urination	☐	☐
Loss of appetite	☐	☐
Change in vision	☐	☐

Lungs	Yes	No
Difficulty breathing	☐	☐
Chronic cough	☐	☐
Spit up blood	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Other lung problems	☐	☐

Muscles, Joints and Nerves	Yes	No
Muscle pain	☐	☐
Joint pain	☐	☐
Loss of coordination	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Shaking	☐	☐
Paralysis	☐	☐
Limited joint movement	☐	☐
Memory loss	☐	☐
Personality changes	☐	☐
Seizures	☐	☐
Difficulty sleeping	☐	☐
Depressed mood	☐	☐

Ears, Nose and Throat	Yes	No
Difficulty hearing	☐	☐
Ringing in ears	☐	☐
Problems with gum/teeth	☐	☐

Cardiovascular	Yes	No
Chest pain/discomfort	☐	☐
Leg pain with exercise	☐	☐
Palpitations	☐	☐
Skipping heart beats	☐	☐
Ankle swelling	☐	☐
Easier to breath sitting up	☐	☐
Ankle swelling	☐	☐
	☐	☐

Stomach and Intestines	Yes	No
Abdominal pain	☐	☐
Blood in stool	☐	☐
Nausea/Vomiting	☐	☐
Diarrhea	☐	☐
Black stools	☐	☐
Vomiting blood	☐	☐
Heart burn	☐	☐
Habitual constipation	☐	☐
Hemorrhoids	☐	☐

Urinary Tract	Yes	No
Excess urination	☐	☐
Pain with urination	☐	☐
Leakage of urine	☐	☐
Urinary shutdown	☐	☐
Excessive urination at night	☐	☐
Retention of urine	☐	☐
Blood in urine	☐	☐
Scanty urine	☐	☐
Discharge (penis/vagina)	☐	☐
Sexual dissatisfaction	☐	☐

Breast	Yes	No
Breast lump	☐	☐
Nipple discharge	☐	☐

Allergy	Yes	No
Hay fever/allergy	☐	☐

Is there anything else you would like to discuss? _____

_____

WOMEN'S HEALTH HISTORY:

First day of most recent menstrual period: _____

Do you have any concerns about your period? ☐No ☐Yes: _____

Age of first period: _____ Frequency of period: _____

Duration of period: _____

Total # of pregnancies: _____ Deliveries: _____ Miscarriages: _____ Abortions: _____

History of abnormal Pap smear? ☐No ☐Yes: _____

History of abnormal Mammogram? ☐No ☐Yes: _____

Do you have concerns about menopause? ☐No ☐Yes: _____

History of Chlamydia/Gonorrhea/Herpes/Syphilis? ☐No ☐Yes: _____

MEN'S HEALTH HISTORY:

History of Chlamydia/Gonorrhea/Herpes/Syphilis? ☐No ☐Yes: _____

Erectile dysfunction? ☐No ☐Yes