# BLANCHARD VALLEY MEDICAL ASSOCIATES MEDICAL HISTORY FORM

**NAME** _____ **Date of birth** _____ **Date** _____
**Soc Sec #**_____ **Home Phone (  )**_____ **Work Phone (  )**_____
**___Married ___Single ___Divorced ___Widowed; Occupation:** _____
**Tobacco Use: YES / NO** _____ **pack/day for** _____ **years Date quit:** _____
**Alcohol Use: YES / NO Beverage** _____ **glasses/wk Beer** _____ **per week**
**Caffeine Use: YES / NO Coffee / Tea** _____ **cups / day Pop** _____ **per day**
**PAST MEDICAL HISTORY:**

| *Hospitalizations* | *Year* | *Surgery / Illness* | *Hospital Name and Address* |
|---|---|---|---|
| *1* | | | |
| *2* | | | |
| *3* | | | |
| *4* | | | |

## PAST ILLNESSES OF YOURSELF AND FAMILY:

| YOU/YOUR FAMILY | | YOU/ YOUR FAMILY | | YOU/YOUR FAMILY | |
|---|---|---|---|---|---|
| ☐ | ☐ ALCOHOLISM | ☐ | ☐ HIGH BLOOD PRESSURE | ☐ | ☐ STROKE |
| ☐ | ☐ ANEMIA | ☐ | ☐ KIDNEY DISEASE | ☐ | ☐ SUICIDE ATTEMPT |
| ☐ | ☐ ASTHMA | ☐ | ☐ LIVER DISEASE | ☐ | ☐ THYROID DISEASE |
| ☐ | ☐ CANCER / TUMOR | ☐ | ☐ HEPATITIS | ☐ | ☐ TUBERCULOSIS, TB |
| ☐ | ☐ DIABETES | ☐ | ☐ LUNG DISEASE | ☐ | ☐ ULCER IN GI TRACT |
| ☐ | ☐ DRUG ABUSE | ☐ | ☐ MENTAL ILLNESS | ☐ | ☐ VENEREAL DISEASE |
| ☐ | ☐ DEPRESSION | ☐ | ☐ OSTEOARTHRITIS | ☐ | ☐ HIGH CHOLESTEROL |
| ☐ | ☐ EPILEPSY / SEIZURES | ☐ | ☐ OSTEOPOROSIS | ☐ | ☐ HIV / IMMUNE DISEASE |
| ☐ | ☐ GLAUCOMA | ☐ | ☐ PHLEBITIS | ☐ | ☐ OTHER _____ |
| ☐ | ☐ HEART DISEASE | ☐ | ☐ RHEUMATIC ARTHRITIS | | _____ |

## CURRENT MEDICATIONS: Include birth control pills, vitamins, and supplements

**MEDICINE NAME HOW TAKEN? WHO PRESCIBES**

_____
_____
_____
_____
_____
_____
_____
_____

## ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS:

**NAME OF MEDICATION REACTION**

_____
_____
_____
_____

## TESTS: Please indicate the date when the following tests were performed (month and year)

**1. Mammogram** _____ **2. Pelvic / Pap** _____ **3. EKG** _____
**4. Rectal Exam** _____ **5. Colonoscopy** _____

## VACCINES: Please indicate the date of your most current vaccine (month and year)

**1. Tetanus** _____ **2. Flu Shot** _____
**3. Pneumonia Shot** _____ **4. Hepatitis B Series** _____

**SIGNATURE OF PHYSICIAN:** _____ **DATE:** _____

**NAME:** _____ **DOB:** _____

**REVIEW OF SYSTEMS:** **Please check each item YES or NO as they relate to your health.**

**CONSTITUTIONAL:**

| | Yes | No |
|---|---|---|
| Weight Loss | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Fever | ☐ | ☐ |

**EYES:**

| | Yes | No |
|---|---|---|
| Glasses/Contacts | ☐ | ☐ |
| Eye Pain | ☐ | ☐ |
| Double Vision | ☐ | ☐ |
| Cataracts | ☐ | ☐ |

**EARS, NOSE, THROAT:**

| | Yes | No |
|---|---|---|
| Difficulty Hearing | ☐ | ☐ |
| Ringing in Ears | ☐ | ☐ |
| Vertigo | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ |
| Nasal Stuffiness | ☐ | ☐ |
| Frequent Sore Throat | ☐ | ☐ |

**CARDIOVASCULAR:**

| | Yes | No |
|---|---|---|
| Murmur | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Palpitations | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Fainting Spells | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Difficulty Lying Flat | ☐ | ☐ |
| Swelling Ankles | ☐ | ☐ |

**ENDOCRINE:**

| | Yes | No |
|---|---|---|
| Loss of Hair | ☐ | ☐ |
| Heat/Cold Intolerance | ☐ | ☐ |

**MUSCULOSKELETAL:**

| | Yes | No |
|---|---|---|
| Joint Pain/Swelling | ☐ | ☐ |
| Stiffness | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ |
| Back Pain | ☐ | ☐ |

**FEMALES ONLY:**

Last Mammogram Date _____
Normal_____Abnormal_____
Last PAP Date _____
Normal_____Abnormal_____
Age Onset of Periods _____
Age Onset of Menopause _____
Periods Regular? Yes_____No____
Number of Pregnancies _____
Babies over 9 pounds? _____

**RESPIRATORY:**

| | Yes | No |
|---|---|---|
| Cough | ☐ | ☐ |
| Coughing Blood | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Chills | ☐ | ☐ |

**GASTROINTESTINAL:**

| | Yes | No |
|---|---|---|
| Heartburn/Reflux | ☐ | ☐ |
| Nausea/Vomiting | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Change in Bowel Movements | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Abdominal Pain | ☐ | ☐ |
| Black or Bloody Stool | ☐ | ☐ |

**GENITOURINARY:**

| | Yes | No |
|---|---|---|
| Burning/Frequency | ☐ | ☐ |
| Blood in Urine | ☐ | ☐ |
| Erectile Dysfunction | ☐ | ☐ |
| Abnormal Discharge | ☐ | ☐ |
| Bladder Leakage | ☐ | ☐ |

**ALLERGIC/IMMUNOLOGIC:**

| | Yes | No |
|---|---|---|
| Hives/Eczema | ☐ | ☐ |
| Hay Fever | ☐ | ☐ |

**PSYCHIATRIC:**

| | Yes | No |
|---|---|---|
| Anxiety/Depression | ☐ | ☐ |
| Mood Swings | ☐ | ☐ |
| Difficulty Sleeping | ☐ | ☐ |

**HEMATOLOGIC/LYMPH:**

| | Yes | No |
|---|---|---|
| Easy Bruising | ☐ | ☐ |
| Gums Bleed Easily | ☐ | ☐ |
| Enlarged Glands | ☐ | ☐ |

**SKIN:**

| | Yes | No |
|---|---|---|
| Rash/Sores | ☐ | ☐ |
| Lesions | ☐ | ☐ |
| Itching/Burning | ☐ | ☐ |

**NEUROLOGICAL:**

| | Yes | No |
|---|---|---|
| Loss of Strength | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Tremors | ☐ | ☐ |
| Memory Loss | ☐ | ☐ |

**SIGNATURE OF PHYSICIAN** _____ **DATE:** _____