Senior Care
MEDICAL ASSOCIATES, INC.

PATIENT MEDICAL HISTORY

Today's Date _____

Patient Name _____ Date of Birth _____

MEDICAL HISTORY – Check all below that apply, and note the year that it started.

❑ **None**		❑ Heart Problem	
❑ Allergy Problem		❑ Hepatitis	
❑ Acid Reflux		❑ Headaches	
❑ Anxiety		❑ High Blood Pressure	
❑ Arthritis		❑ High Cholesterol	
❑ Asthma		❑ Kidney Problem	
❑ Atrial Fibrillation		❑ Liver Problem	
❑ Blood Clots		❑ Lung Problem	
❑ Blood Problem		❑ Osteoporosis	
❑ Cancer		❑ Prostate Problem	
❑ Depression		❑ Seizures	
❑ Diabetes		❑ Stroke	
❑ Gastrointestinal Problem		❑ Thyroid Problem	

❑ Other: _____

_____

SURGICAL HISTORY – Check all below that apply, and note the year that is was performed.

	Year		Year
❑ **None**		❑ Gall Bladder	
❑ Appendix		❑ Hernia	
❑ Breast Surgery		❑ Hip Surgery	
❑ Cancer surgery		❑ Hysterectomy	
❑ Cataract		❑ Knee Surgery	

HEALTH MAINTENANCE – When did you last have any of the following exams and/or vaccinations?

Exam	Year	Vaccine	Year
Advanced Directive		Last Flu Shot	
Bone Density		Pneumovax	
Colonoscopy		Prevnar 13	
Eye Exam		Shingles	
Mammogram		Tetanus	
Pap / Pelvic Exam			
Prostate Exam			

PATIENT MEDICAL HISTORY (Page 2)

Today's Date _____

Patient Name _____ Date of Birth _____

FAMILY HISTORY – Please check all below that apply. Please list any additional information regarding family history in the "notes" section below.

Diagnosis	Mother	Father	Brother	Sister	Other:
Alcohol Problem	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑
Bleeding Problems	❑	❑	❑	❑	❑
Blood Clots	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Dementia / Alzheimers	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Lung Problem	❑	❑	❑	❑	❑
Heart Problem	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Mental Illness/Suicide	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Thyroid Problem	❑	❑	❑	❑	❑

Notes: _____

SOCIAL HISTORY – Check off any that apply.

Do you exercise daily? ❑Yes ❑No If yes, how often? _____ Type of Exercise: _____

Do you drink alcohol? ❑Yes ❑No Amount: _____ How Often? _____

❑Former Year Quit: _____

Do you or have you ever smoked tobacco? ❑Current ❑Former ❑Never

Cigarettes/day: _____ Years Used: _____ Year Quit: _____

Do you or have you ever used recreational drugs? ❑Yes ❑No If yes, what have you used? _____

How often? _____

FUNCTIONAL HISTORY – Check off any that apply.

- ❑ Hearing Aid
- ❑ Dentures
- ❑ Walker / Cane
- ❑ Glasses / Contacts

PATIENT MEDICAL HISTORY (Page 3)

Today's Date _____

Patient Name _____ Date of Birth _____

ALLERGIES - List all known allergies(drugs, food, animals, etc.).

[ ] **No known allergies**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS – List all medications that you take. Include prescription and non-prescription, as well as the dosage and frequency.

[ ] **I do not take any medications**

Medication Name	Dosage / Frequency