Senior Care
MEDICAL ASSOCIATES, INC.

PATIENT MEDICAL HISTORY

Today's Date _____

Patient Name _____ Date of Birth _____

Who referred you to my practice? Name? _____

Main reason for today's visit: _____
Other concerns: _____
_____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor
Please list healthcare providers & their specialty you see regularly:
Prior PCP _____
_____
_____
List any medical suppliers you use (e.g. respiratory supplies, etc): _____
_____

SOCIAL HISTORY – Check off any that apply

Residence: □ Home/Apt □ Assisted Living □ Board and Care Name _____

Do you or have you ever smoked tobacco?

❑ Never

❑ Former: Year Quit: _____
How many packs/day did you previously smoke? _____ Years Used: _____

❑ Current: packs/day: _____ Years Used: _____ Ready to quit: ❑ Yes ❑ No

❑ Other Tobacco/ ❑ Vaping / ❑ Electronic Cigarettes? How often used per day _____

Do you drink alcohol? ❑ Yes ❑ No # of drinks/week: _____ Type: ❑ Beer ❑ Wine ❑ Liquor _____
❑Former Year Quit: _____

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

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

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PATIENT MEDICAL HISTORY (Page 2)

Today's Date _____

Patient Name _____ Date of Birth _____

SOCIAL HISTORY:

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence
□ disabled □ homemaker □ other _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____ Number of children: _____

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

Exam	Year	Vaccine	Year
Bone Density (DEXA)	_____	Last Flu Shot	_____
Colonoscopy	_____	Pneumovax	_____
Eye Exam	_____	Prevnar 13 or 20	_____
Hearing Test(Audiogram)	_____	Shingles	_____
Mammogram	_____	Tetanus	_____
Pap / Pelvic Exam	_____	COVID 19	_____
Prostate Exam / PSA	_____	Other	_____

FUNCTIONAL HISTORY – Check off if you use the following

❑ Hearing Aid ❑ Dentures ❑ Implants ❑ Cane ❑ Walker ❑ Wheelchair ❑ Glasses / Contacts

MEDICAL FORMS:

Please check any of the following forms you have completed:
□ Advance Directive for Health Care (ADHC)
□ Durable Power of Attorney (DPA) for healthcare decisions
□ Living Will
□ POLST (Physician Orders for Life Sustaining Therapy)
□ Know about these or have the forms but have not completed them
□ Don't know what these are

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PATIENT MEDICAL HISTORY (Page 3)

Today's Date _____

Patient Name _____ Date of Birth _____

MEDICAL HISTORY: **Please check box if you have or previously had (past) any of the following conditions:**

Condition	*Now*	*Past*	*Comments*
Alcohol/ Drug Abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis(Osteoarthritis)			
Arthritis(Rheumatoid or other)			
Asthma			
Bladder Condition			
Blood Clot (Leg) or (Lung)			
Breast Lump(benign)			
Cancer Breast			
Cancer Colon			
Cancer Lung			
Cancer Ovarian			
Cancer Prostate			
Cancer (Other)			
COPD/ Chronic Lung Disease			
Coronary Artery Disease/ Heart Disease			
Depression			
Diabetes			
Diverticulosis			

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PATIENT MEDICAL HISTORY (Page 4)

Today's Date _____

Patient Name _____ Date of Birth _____

MEDICAL HISTORY: **Please check box if you have or previously had (past) any of the following conditions:**

Fractures (broken bones)			where?
Gallbladder Disease			
GERD/ Heartburn			
Glaucoma			
Gout			
Gynecological Conditions			
Headaches - Migraine or Other			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease/ Stones			
Liver Disease			
Memory Loss /Alzheimers or other			
Neurological- Seizures or Strokes			
Osteoporosis			
Prostate Enlargement (BPH)			
Prostate Nodules (benign)			
Skin Condition (rash or other)			
Sleep Apnea			
Stomach Ulcer			

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PATIENT MEDICAL HISTORY (Page 5)

Today's Date _____

Patient Name _____ Date of Birth _____

Thyroid Disorder (nodules / low and high level)			
Other (list)			
Other (list)			
Other (list)			

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

Surgical Procedure	**Yes**	**Year**	**Comments**
Abdominal Surgery			
Angiogram			
Appendectomy			
Biopsy (location in comments)			
Breast Surgery			
Cataract Surgery			
Coronary Bypass/ Stent			
C-section			
Gallbladder Surgery			
Hysterectomy(partial or total)			
Heart Surgery			
Hip / Knee / Back Surgery			

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PATIENT MEDICAL HISTORY (Page 6)

Today's Date _____

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Joint Replacement			
Tonsillectomy			
Other (list)			
Other (list)			

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/Drug Condition	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑
Bleeding Disorders	❑	❑	❑	❑	❑
Blood Clots	❑	❑	❑	❑	❑
Cancer (specify Type below)	❑	❑	❑	❑	❑
Dementia / Alzheimer's	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Lung Condition	❑	❑	❑	❑	❑
Heart Condition	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Mental Illness/Anxiety	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Thyroid Problem	❑	❑	❑	❑	❑

Notes: Other

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PATIENT MEDICAL HISTORY (Page 7)

Today's Date _____

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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

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