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:_____

_____

_____

_____

List any medical suppliers you use (e.g. respiratory supplies, etc): _____

_____

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)			

Condition	***Now***	***Past***	***Comments***
Cancer Breast			
Cancer Colon			
Cancer Lung			
Cancer Ovarian			
Cancer Prostate			
Cancer (Other)			

COPD/ Chronic Lung Disease			
Coronary Artery Disease/ Heart Disease			
Depression			
Diabetes			
Diverticulosis			
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			

Condition	***Now***	***Past***	***Comments***
Osteoporosis or Osteopenia			
Prostate Enlargement (BPH)			
Prostate Nodules (benign)			
Skin Condition (rash or other)			
Sleep Apnea			
Stomach Ulcer			
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			
Joint Replacement			

Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other (list)			
Other (list)			
Other (list)			

SOCIAL HISTORY – Check off any that apply

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: _____

Do you drink alcohol? ❑Yes ❑No ❑ Occasionally

❑Former Year Quit: _____

# of drinks/week: _____ Type __ Beer __ Wine __ Liquor

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? _____

Type of Exercise: _____

Occupation (or prior occupation): _____

Employer: _____

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

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

Spouse/partner's name: _____

Number of children: _____

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

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PATIENT MEDICAL HISTORY (cont)

Today's Date _____

Patient Name _____ Date of Birth _____

FUNCTIONAL HISTORY – Check off any that apply.

❑ Hearing Aid ❑ Dentures ❑ Wheelchair

❑ Walker / Cane ❑ Glasses / Contacts ❑ Other _____

HEALTH MAINTENANCE – When did you LAST 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 or PSA	_____	Other	_____

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 / Wants more info

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PATIENT MEDICAL HISTORY (cont)

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 / Alzheimer's	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Lung Problem	❑	❑	❑	❑	❑
Heart Problem	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Mental Illness/Suicide	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Thyroid Problem	❑	❑	❑	❑	❑

Notes:

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PATIENT MEDICAL HISTORY (cont)

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