CATAWBA VALLEY FAMILY MEDICINE
LONG VIEW

Medical Health History Form

Patients Name: _____

DOB: _____ **Age:** _____

The following medical questionnaire is confidential and will not be released to anyone unless you authorize us to do so.

Current Medications: What medications are you currently taking (please include name, dose, and how often you take)?

_____

_____

_____

_____

_____

_____

_____

_____

Medical History: Have you ever had any of the following? If so, please explain in detail in the space to the right of each listed.

Allergies/Intolerances: Please list any allergies or intolerances

	Yes		Yes
1. High Blood Pressure	☐ _____	14. Other Mental Illness	☐ _____
2. Diabetes	☐ _____	15. Anemia or Other Blood Condition	☐ _____
3. Cancer	☐ _____	16. Sexually Transmitted Disease(s)	☐ _____
4. Heart Trouble	☐ _____	17. Other Reproductive Problems	☐ _____
5. High cholesterol	☐ _____	18. Seizures or Epilepsy	☐ _____
6. Hepatitis or liver problems	☐ _____	19. Stroke	☐ _____
7. Kidney Disease	☐ _____	20. Other Neurological Problems	☐ _____
8. Bladder or urinary problems	☐ _____	21. Thyroid Problems	☐ _____
9. Bowel or gastrointestinal problems	☐ _____	22. Arthritis or other joint problems	☐ _____
10. Asthma, Allergies, or hay fever	☐ _____	23. Drug or alcohol abuse	☐ _____
11. Migraine Headaches	☐ _____	24. Skin disease or cancer	☐ _____
12. Lung/Respiratory Disease	☐ _____	25. Any other serious medical conditions?	☐ _____
13. Anxiety/Depression	☐ _____		

and what reaction happens. Please list medication allergies and any other allergies.

_____

_____

Surgical and Hospitalization History: Have you ever had surgeries, or have you ever been hospitalized? Please list below along with date.

_____

Family History: Have any blood relatives (parents, grandparents, uncles, aunts, brothers, sisters cousins, children) ever had?

	Yes	Who?		Yes	Who?
Allergies or Asthma	☐	_____	High Blood Pressure	☐	_____
Breast Cancer	☐	_____	Stroke	☐	_____
Colon Cancer	☐	_____	Kidney Disease	☐	_____
Prostate Cancer	☐	_____	Birth Defects	☐	_____
Other Cancer	☐	_____	Blood Abnormality	☐	_____
Diabetes	☐	_____	Seizures/Epilepsy	☐	_____
Heart Trouble	☐	_____	Mental Illness	☐	_____

Social History:

Tobacco Use: ☐ Do Not Use ☐Cigarettes ☐Oral Tobacco Number of cigarettes per day_____How soon after you wake up do you smoke your first cigarette?_____ Are you interested in quitting? ☐Yes ☐No

Alcohol Use: ☐ Do Not Use ☐Social Drinker Number of Drinks per week_____ Type of alcohol_____

Drug Use: ☐Do Not Use ☐Marijuana ☐IV Drugs ☐Other_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other_____

Occupation: _____Employer:_____Education Level:_____

Are you sexually active? ☐Currently ☐Previously but not currently ☐High Risk Sexual Activity (multiple partners, history of STDs)

Exercise: ☐None ☐Occasionally ☐Regularly What Kind?_____For How Long?_____

Caffeine Use: ☐Do Not Use ☐Occasionally Number of times per day_____Type of Caffeine_____

Review of Systems: Check all that you have had in the past 3 months

☐ Fatigue	☐Sore Throat	☐Frequent Urination	☐Sleep Changes
☐ Fever/Chills	☐Sore(s) in Mouth	☐Blood in Urine	☐Depression
☐ Loss of Appetite	☐Chest Pain	☐Bladder Control Loss	☐Problems Focusing
☐ Night Sweats	☐Palpitations	☐Painful Urination	☐Disturbing Thoughts
☐ Sleep Disturbance	☐Irregular Heartbeat	☐Back Pain	☐Hyperactivity
☐ Weight Gain	☐Ankle/Leg Swelling	☐Joint Pain	☐Moodiness
☐ Weight Loss	☐Cough	☐Joint Stiffness	☐Suicidal Thoughts
☐ Vision Changes	☐Snoring	☐Limited Movement	☐Change in Periods
☐ Irritated Eyes	☐Irregular Breathing	☐Muscle Pain/Cramps	☐Excessive Sweating
☐ Dizziness	☐Wheezing	☐Muscle Weakness	☐Excessive Thirst
☐ Hearing Loss	☐Abdominal Pain	☐Neck Pain	☐Excessive Hunger
☐ Ringing in Ears	☐Constipation	☐Skin Changes/Rashes	☐Problems with Heat
☐ Hoarseness	☐Diarrhea	☐Fainting/Black Outs	☐Problems with Cold
☐ Nasal Obstruction	☐Heartburn	☐Speech Difficulty	☐Abnormal Bleeding
☐ Nose Bleeds	☐Swallowing Problems	☐Headaches	☐Bruising
☐ Postnasal Drip	☐Nausea or Vomiting	☐Memory Loss	
☐ Sinusitis	☐Difficulty Urinating	☐Anxiety	

Screenings/Prevention:

Have you ever had any of the following immunizations? If so, when?

☐Influenza (flu) ☐Pneumonia ☐Tetanus ☐Hepatitis B

Date: _____ Date:_____ Date:_____ Date:_____

When was the last time you had fasting blood work completed?_____Was it normal? ☐Yes ☐No

Male Patients: Please complete the following:

When was your last prostate exam or PSA blood test level checked? _____

When was the last time you were checked for colon/rectal cancer (either with colonoscopy or through rectal exam)?_____

Female patients: Please complete the following:

Last Menstrual Period began: _____ Are you periods regular? ☐Yes ☐No

Age You Started Menstruation: _____ How often do you menstruate? Every_____days.

How long do your periods last?_____days. Bleeding is ☐mild ☐moderate ☐severe.

Do you have any cramps? ☐Yes ☐No

Total Number of Pregnancies:_____Births:_____Miscarriages:_____

Do you use birth control? ☐Yes ☐No

What Form of Birth Control?_____Are you happy with this method? ☐Yes ☐No

When was your last pap smear? _____ History of any abnormal mammograms? ☐Yes ☐No

When was the last time you were checked for colon/rectal cancer (either with colonoscopy or through rectal exam)?_____

Other Concerns: Any other concerns you would like to address with the Provider today during your visit?

_____

_____