DeKalb Family Practice & Geriatrics

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Medical History

Full Name_____ Date of Birth_____ Date_____
Do you have a living will? □ Yes □ No Healthcare Proxy? □ Yes □ No If yes, who?_____
Do you have Advance Directives for Healthcare? □ Yes □ No If yes, please provide a copy to front office.
Please list all specialty physicians you see:_____
_____

Present Health Concerns (Please list reasons for your visit today in order of priority):

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies:

Medication	Reaction or Side Effect

Medications (including non-prescription medications, birth control, vitamins, herbs and supplements):

Medications	Dosage

Past Medical History (Please check any illnesses or conditions you have had):

□ Acid Reflux	□ Bronchitis	□ Glaucoma	□ Hypertension	□ Sickle Cell Disease
□ Alcoholism	□ Cancer_____	□ Gout	□ Irregular heartbeat	□ Sleep Apnea
□ Anemia	□ Crohn's Disease	□ Hay Fever	□ Jaundice	□ Stomach Ulcer
□ Aneurysm	□ COPD	□ Headaches	□ Kidney Disease	□ Stroke
□ Anxiety Disorder	□ Depression	□ Heart Disease	□ Kidney Stones	□ Substance Abuse
□ Arthritis	□ Diabetes	□ Heart Failure	□ Liver Disease	□ Thyroid Disease
□ Asthma	□ Emphysema	□ Heart Murmur	□ Obesity	□ Tuberculosis
□ Blood Disorder	□ Epilepsy	□ Hepatitis A, B or C	□ Osteoporosis	□ Ulcerative Colitis
□ Blood Clots	□ Fractures	□ High Cholesterol	□ Prostate Problems	□ Other _____
□ Blood Transfusion	□Gallbladder problem	□ HIV/AIDS	□ STD _____	□_____

Past Surgical/Hospitalization History (Please list all prior operations and dates):

Operations	Date	Hospitalizations	Date

Family Medical History (List all medical illnesses in your blood relatives): □ Adopted

Family Member	Major Medical Problems	Family Member	Major Medical Problems
Mother		Father	
Maternal Grandparents		Paternal Grandparents	
Aunts		Uncles	
Sisters		Brothers	
Daughters		Sons	

Social History

Occupation: _____ Marital Status: _____ Children:□ Yes □ No
Do you drink alcohol? □ Yes □ No How Often? _____ How many drinks?_____
Do you smoke? □ Yes □ No Packs per day?_____ How many years?_____
Are you a former smoker? □ Yes □ No Year quit?_____ Do you chew tobacco? □ Yes □ No
Do you Exercise? □ Yes □ No How long? _____ per day/week/month
Do you use recreational/illegal drugs? □ Yes □ No If yes, what drug(s)?_____
Have you ever worked with asbestos or other hazardous materials? □ Yes □ No

Health Maintenance:

Last annual physical exam _____ Last stress test _____ Last cholesterol check _____
Last menstrual period _____ Last Pap smear _____ Last mammogram _____
Last prostate screening _____ Last Colonoscopy _____ Last bone density test _____
Immunizations: Flu _____ Pneumovax _____ Tetanus _____ Hepatitis A _____ Hepatitis B _____

Review of Symptoms (please check if you recently had the following symptoms):

□ Weight Gain/Loss	□ Runny nose	□ Palpitations	□ Urinary leakage	□ Anxiety/Stress
□ Excessive thirst	□ Nose Bleed	□ Fainting	□ Painful intercourse	□ Mood changes
□ Feeling too cold	□ Fever/Chills	□ Nausea/Vomiting	□ Erection problems	□ Depression
□ Feeling too hot	□ Cough	□ Diarrhea	□ Penis discharge	□Skin rash/discoloration
□ Night sweats	□ Blood in sputum	□ Constipation	□ Vaginal discharge	□ Joint pain
□ Weakness	□ Shortness of breath	□ Blood in stool	□ Breast lump/pain	□ Back pain
□ Fatigue	□ Chest discomfort	□ Blood in Vomit	□ Headache	□ Leg pain
□ Insomnia	□ Irregular Heart beat	□ Heartburn	□ Dizziness	□ Leg swelling
□ Change in Hearing	□ Exercise Intolerance	□ Easy bruising	□ Memory problems	□ Other _____
□ Change in Vision	□Difficulty swallowing	□ Urinary problems	□ Tingling/Numbness	□_____

Patient/Guardian Signature | Patient Name (Please print) | Date | Time

Relation to patient | Reason patient is unable to sign