**Four Oaks Medical Clinic**
**Medical History Form**

Patient name: _____ Date of Birth: _____ Today's Date: _____

***ALLERGIES***

Allergies: ☐ No ☐ Yes, please list:

| *Drug Name* | *Drug Reaction* |
|---|---|
| | |
| | |
| | |

***CURRENT MEDICATIONS*** **(include over the counter medications, herbals, supplements, etc.)**

| *Name* | *Dose strength* | *How often taken* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

***PERSONAL FAMILY HISTORY***

| | ***Personal History*** | ***Family History*** | *Maternal (M) Paternal (P)* |
|---|---|---|---|
| Acid Reflux | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Asthma | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Cancer, types | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Lung Disease (COPD) | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| CVS (Stroke) | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Diabetes Mellitus | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Headaches, migraine | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Heart Disease | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| High Blood Pressure | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| High Cholesterol | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Kidney Disease | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Osteoarthritis | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Osteoporosis | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Other: _____ | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Other: _____ | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Other: _____ | ☐ Yes ☐ No | ☐ Yes ☐ No | Family member: _____ |
| Sexually Transmiited Disease Describe: _____ | ☐ Yes ☐ No | | |
| Environmental Exposure | ☐ Yes ☐ No | | |

***Continued on 2nd Page***

| ADVANCE DIRECTIVES | Living Will ☐ Yes ☐ No | Organ Donation ☐ Yes ☐ No | Durable Power of Attorney: ☐ Yes ☐ No<br>Who? _____ |
|---|---|---|---|

***FOR WOMEN ONLY***

***GYNECOLOGICAL HISTORY***

| #Pregnancies: | # Live births: | # Miscarriages: | # Abortions: |
|---|---|---|---|

| # of Vaginal Deliveries: _____<br># of C-Sectrion Deliveries: ____ | Pregnancy complications: ☐ Yes ☐ No<br>If yes, please list | Age at first Menstrual Period: _____<br>Age at Memopause: _____ |
|---|---|---|
| Date of last Pap Smear _____<br>Results: ☐ Normal ☐ Abnormal | Date of last mammogram: _____<br>Results: ☐ Normal ☐ Abnormal | Date of last Bone Density: _____<br>Results: ☐ Normal ☐ Abnormal |

***HOSPITALIZATIONS***

| *Reason for Hospitalization* | *Date of Hospitalization* | *Hospital/Physician* |
|---|---|---|
| | | |
| | | |
| | | |

***SURGICAL HISTORY***

| *Type of Surgery* | *Date of Surgery* | *Hospital/Physician* |
|---|---|---|
| | | |
| | | |
| | | |

| *Procedures* | *Date of Procedure* | *Hospital/Physician* |
|---|---|---|
| Colonoscopy | | |
| Heart Catheterizations | | |
| Other | | |

***FAMILY HISTORY***

| | *Alive?* | *Birth Year* | *Age at Death* | *Cause of Death* |
|---|---|---|---|---|
| Father | ☐ Yes ☐ No | | | |
| Mother | ☐ Yes ☐ No | | | |
| | *How many?* | *# Alive* | *Birth Year(s)* | *If deceased, age & cause of death* |
| Brother(s) | | | | |
| Sister(s) | | | | |
| Children<br>Sons | | | | |
| Daughters | | | | |

***SOCIAL HISTORY***

| Occupation: | |
|---|---|
| Marital Status: | ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed |
| Hobbies/Recreation:<br>(please list) | |

| | | *Frequency* | *Quality* | *Type* | *For Past Use: Date Quit* |
|---|---|---|---|---|---|
| Exercise: | ☐ Yes ☐ No | | | | |
| Tobacco: | ☐ Never ☐ Present ☐ Past | | | | |
| Alcohol: | ☐ Never ☐ Present ☐ Past | | | | |
| Caffeine: | ☐ Yes ☐ No | | | | |
| Drug Use | ☐ Never ☐ Present ☐ Past | | | | |

***IMMUNIZATIONS***

Date of Last Tetanus: _____ Date of Last Pneumovac: _____ Date of Last Flu Vaccine:_____

Date of Last Shingles Vaccine: _____

***Continued on 3rd Page***

| ***OTHER MEDICAL PROVIDERS*** | | |
|---|---|---|
| Name: | Speciality: | Phone #: |
| Name: | Speciality: | Phone #: |
| Name: | Speciality: | Phone #: |

Signature: _____ Printed Name: _____ Date: _____