Medical History Record

Meridian Internal Medicine and Primary Care, Inc.

Full Name: ______________________ Age: _____ Date of Birth: ______________

Marital Status: Married Social Security #: ______________

Address: ____

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

List Current/Previous Doctors and their specialty:

____

ALLERGIES AND REACTIONS

____

____

____

____

MEDICATIONS (list dosage and how you take them,including non-prescription, herbs, birth control)

____

____

____

PAST MEDICAL ILLNESSES (Please check if you have had the following):

- ❑ Alcohol/drug addiction
- ❑ Anemia
- ❑ Aneurysm
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disorder
- ❑ Blood Clot
- ❑ Blood transfusion
- ❑ Cancer (Type): ____________
- ❑ Crohn's Disease
- ❑ COPD/Emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Gout
- ❑ Hay fever
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis B or C
- ❑ High Cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Seizure
- ❑ Sexually Transmitted Disease (Type): ____________
- ❑ Sickle Cell Disease
- ❑ Sleep Apnea
- ❑ Stomach Ulcer
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ (Positive) TB skin test
- ❑ Ulcerative Colitis
- ❑ Other: ____________

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY

Family Members	Major Medical Problems	If Deceased, Causes	Age of Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters 1) ❑ M ❑ F			
2) ❑ M ❑ F			
3) ❑ M ❑ F			
Sons and Daughters 1) ❑ M ❑ F			
2) ❑ M ❑ F			
3) ❑ M ❑ F			

SOCIAL HISTORY

Meridian Internal Medicine and Primary Care, Inc.

Occupation:	Marital Status: Married	Children: ❑ Yes ❑ No
Do you drink alcohol? ❑ Yes ❑ No	How often?	How many drinks?
Do you smoke? ❑ Yes ❑ No Are you a former smoker? ❑ Yes ❑ No Do you chew snuff? ❑ Yes ❑ No	Packs per day: ❑ .25 ❑ 1.5 ❑ .5 ❑ 2.0 ❑ 1.0	How many years? _______ Year quit? _______
Do you use illegal drugs? ❑ Yes ❑ No		
Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No		Which ones?
Do you have a living will? ❑ Yes ❑ No	Healthcare proxy? ❑ Yes ❑ No	If so, who?

HEALTH MAINTENANCE

Last menstrual period: ________________ Last Pap smear: ________________ Last mammogram: ________________

Last colonoscopy: ____________ Last prostate cancer screening: ____________ Last Bone Density Scan: ____________

Immunizations: ❑ Pneumovax_________ ❑ Flu_________ ❑ Tetanus_________ ❑ Hep A_________ ❑ Hep B_________

REVIEW OF YOUR SYMPTOMS (Please check if you have recently had the following symptoms):

❑ Weight gain
❑ Weight loss
❑ Night sweats
❑ Weakness
❑ Fatigue
❑ Insomnia
❑ Change in hearing
❑ Change in vision
❑ Runny nose
❑ Nose bleed
❑ Fever
❑ Blood in sputum
❑ Shortness of breath
❑ Persistent cough
❑ Chest discomfort
❑ Palpitations
❑ Fainting

❑ Change in exercise tolerance
❑ Difficulty swallowing
❑ Indigestion or heartburn
❑ Nausea
❑ Vomiting
❑ Constipation
❑ Diarrhea
❑ Change in bowl habit
❑ Blood in vomit
❑ Blood in stool
❑ Difficulty urinating
❑ Trouble holding urine
❑ Frequency of urination
❑ Penis discharge
❑ Vaginal discharge
❑ Nipple discharge
❑ Breast pain

❑ Breast lump
❑ Pain with intercourse
❑ Feeling too hot
❑ Feeling too cold
❑ Dizziness
❑ Headaches
❑ Memory loss
❑ Numbness/tingling
❑ Tremor
❑ Uncontrollable mood swings
❑ Anxiety
❑ Depression
❑ Skin Rash
❑ Back pain
❑ Leg pain
❑ Leg swelling
❑ Other: ______________________

Please list all your reason(s) for visiting today in order of priority:

1.

2.

3.

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