Patient Medical History Form

First Name:	Last Name:	Birth Date:
Married? ☐ Yes ☐ No	Spouse Name:	Your Occupation:
Children Names / Ages:		

Preferred Pharmacy (if medication not available at Appleton Clinics):

Allergies to Medications, Latex or Dyes ☐ None ☐ Yes *please list*:

Current Medications (Prescriptions, Non-Prescriptions) ☐ None ☐ Yes *please list:*

Your Health History (please check all that apply)

	ENT		GENITOURINARY		SKIN
	Eye Problems		Urinary Infections		Psoriasis
	Sinus Problems		Kidney Disease / Stones		Skin Disorders
	Hearing Loss		Erectile Dysfunction		Melanoma
			STD		
CARDIOVASCULAR			Urinary Incontinence		
	Abnormal EKG	**MUSCULOSKELETAL**		**PSYCH**	
	Chest Pain		Arthritis / Osteo		ADD/ADHD
	Heart Attack		Arthritis / Rheumatoid		Anxiety
	Heart Disease		Gout		Depressions
	High Blood Pressure		Neck / Spinal Problems		Memory Loss
	High Cholesterol	**NEUROLOGICAL**			OCD
	Stroke		Concussion		Suicidal Thoughts / Attempts
	Peripheral Vascular Disease		Headaches		
PULMONARY			Migraines		
	Asthma		Epilepsy / Seizures	**OTHER**	
	Emphysema / COPD	**HEMATOLOGICAL**			
	Shortness of Breath		Anemia		
	Sleep Apnea		Bleeding Disorders		
GASTROINTESTINAL			Blood Clots		
	Acid Reflux		Cancer		
	Constipation	**ENDOCRINE**			
	Diarrhea		Diabetes		
	Irritable Bowel		Thyroid Disease		
	Gall Bladder Disease		Pancreatitis		
	Hernia				
	Liver Disease				

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Health Maintenance	NO	YES	YEAR			NO	YES	YEAR
Colonoscopy					Bone Density			
Mammogram					Pap Smear			
Physical Exam								

Past Surgeries (include Date)	YEAR

Social History	NO	YES				NO	YES	
Smoking			Pack(s) Day	# years	Have you quit?			
Alcohol			Drinks / Day	Drinks / week				
Recreational drugs								
Special diet			If yes, describe:					
Regular exercise			If yes, describe:					

Family History (please check all applicable boxes)

Illness	Father	Mother	Sibling	Child	
Asthma					
Bleeding Disorders					
Breast Cancer					
Colon Cancer					
Depression/Anxiety					
Diabetes					**GYN/OB History**
Drug / Alcohol Addiction					Menopause ☐ N ☐ Y (if yes, Age:)
Heart Disease					Abnormal Pap ☐ N ☐ Y If yes, approx. date:
High Blood Pressure					Total # of pregnancies:
High Cholesterol					
Kidney Disease					
Leukemia					
Liver Disease					
Lung Cancer					
Osteoporosis					
Ovarian Cancer					
Pancreatic Cancer					
Rheumatoid Arthritis					
Stroke					
Thyroid Disease					
Other:					

Immunizations	NO	YES		NO	YES	
Hepatitis B Series			Recent Pneumonia Vaccine			
Gardasil Series			Recent Flu Vaccine			
Chicken Pox immunization or disease			Shingles Vaccine			

Comments / Additional Information:

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