AppletonClinics™

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				
Drug / Alcohol Addiction				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Leukemia				
Liver Disease				
Lung Cancer				
Osteoporosis				
Ovarian Cancer				
Pancreatic Cancer				
Rheumatoid Arthritis				
Stroke				
Thyroid Disease				
Other:				

GYN/OB History

Menopause ( ) N ( ) Y (if yes, Age:)

Abnormal Pap ( ) N ( ) Y If yes, approx. date:

Total # of pregnancies:

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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