Boones Creek Medical

PATIENT MEDICAL HISTORY

Patient's Name _____Guardian's Name (if under 18)_____

Allergies (Medications or Environmental/Food)	
Medication or Other (Environmental)	Reaction

Family History
(Please check if your family has a history of any of these diseases)

Medical Condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sister	Brother	Other
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Suicide									
Other									

If your mother, father, brothers or sisters are deceased, please list their age at the time of their death and the cause.

Relationship	Cause of Death	Age at Death	Relationship	Cause of Death	Age at Death

Your Health History
(Please check if you have had any of the following)

	Abnormal Heart Rhythm		Chronic Pain		Heart Attack		Kidney Stones
	Allergies (any)		Chronic Kidney Disease		Heartburn or GERD		Mental Illness
	Anemia		Congestive Heart Failure		Heart Murmur		Neuropathy
	Anxiety or Stress		Depression		Hepatitis		Osteoporosis
	Asthma		Diabetes		High Blood Pressure		Peripheral Vascular Disease
	Arthritis		Emphysema or COPD		High Cholesterol		Seizures or Epilepsy
	Atrial Fibrillation		Gallbladder Disease		HIV or AIDS		Sleep Apnea
	Colitis or Crohn's Disease		Gout		Irritable Bowel Syndrome		Stroke
	Cancer		Headaches or Migraines		Kidney Failure		Thyroid Disease

Preventive Health History
Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician	Vaccine Type	Date
Colonoscopy				Tetanus (Td)	
Cholesterol Labs				Tetanus with pertussis (Tdap)	
Cardiac Stress Test				Prevnar 13 (Pneumonia)	
Bone Density				Pneumovax 23 (Pneumonia)	
Mammogram				Hepatitis B	
Breast Exam				Influenza (flu)	
PAP Smear				Zostavax (Shingles)	
Dental Exam				Shingrix (Shingles)	
Eye Exam				Other	

OB/GYN History	
Number of pregnancies	
Number of full term	
Number of premature	
Number of miscarriages	
Number of living children	

Accidents or Trauma

Have you ever had a severe accident? **YES** **NO** Do you have any metal pins/plates in your body? **YES** **NO** **If yes, please describe**

Patient Name _____ Date of Birth _____

Past Surgical History			
Date	Surgery	Date	Surgery

Medications, Vitamins and Supplements					
Medication Name	Strength	Frequency	Medication Name	Strength	Frequency

Medical Equipment/Devices Please check any devices you use	
	Power Wheelchair
	Manual Wheelchair
	Cane
	Walker
	CPAP or BiPAP
	Overnight Oxygen
	Continuous Oxygen

Care Team Please list any other physicians/specialists that are assisting in your care and their specialty	
Physician Name	Specialty

Health Habits and Social History

Are you able to care for yourself? Yes No Do you have difficulty seeing? Yes No Do you have difficulty hearing? Yes No

Do you now or have you ever smoked? Yes No If yes, how many packs per day? _____ At what age did you start? _____

Do you use any other forms of tobacco or nicotine? Yes No If yes, what type and how much? _____

Do you drink alcohol? Yes No If yes, what type and how often? _____

Do you drink caffeine? Yes No If yes, how may drinks containing caffeine per day? _____

Do you use any illicit or recreational drugs? Yes No If yes, what type and how often?_____

Do you have an advanced directive or living will? Yes No *(If yes please provide a copy to our office to add to your chart)*

Are you exposed to second hand smoke in your home? Yes No Do you use sunscreen routinely? Yes No

Do you feel stressed (tense, restless, nervous, or anxious)? Not at all A little To some extent Rather Often Very often

Are you currently employed? Yes No Retired Disabled If yes, what is your occupation?_____

Do you follow any special diet? Yes No If yes, what type? _____

What is your exercise level? None Occasional Moderate Heavy

Please list any other pertinent medical information you feel we need to know _____

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