PIEDMONT MEDICAL
ASSOCIATES

Medical History

Full name:____________________ Date of birth:____________ Date:____________

Primary doctor:____________________

Doctor who requested today's visit: ____________________

List current/previous doctors and their specialty:____________________

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ALLERGIES AND REACTIONS

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

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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):
  - ❑ Breast ❑ Ovarian
  - ❑ Colon ❑ Uterine
  - ❑ ____________
- ❑ 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:____________

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OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ❑ Adopted

Family Members		Major Medical Problems	If Deceased, Causes	Age at 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

Occupation: Marital Status: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke? ❑ Yes ❑ No
Are you a former smoke? ❑ Yes ❑ No
Do you chew tobacco? ❑ Yes ❑ No

Packs per day: ❑ ¼ pack ❑ 1½ packs ❑ ½ pack ❑ 2 packs ❑ 1 pack ❑ Other:________

How many years?_________
Year quit?_______________

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?
Advanced Directive for Healthcare

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 bowel habit
- ❑ Blood in vomit
- ❑ Blood in stool
- ❑ Difficulty urinating
- ❑ Trouble holding urine
- ❑ Frequency of urination
- ❑ Penis discharge
- ❑ Vaginal discharge/bleeding
- ❑ 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. ____

______________________ Patient/Designee signature
______________________ Patient name (**PRINT**)
__________ Date
__________ Time

______________________ Relationship to patient
______________________ Reason patient is unable to sign