guardiant
Health care that empowers

MEDICAL HISTORY FORM

Name: ______________________ Date of birth: ____________________ Today's date: ____________________

Local pharmacy name: __________________________ Mail order pharmacy name: ______________________

Address: __________________________ Mail order pharmacy fax: ______________________

Phone: __________________________

Medications ❐ I do not take any medications

(Include prescription, over-the-counter medication, birth control, vitamins, herbal supplements)

Medication name	**Dose**	**Frequency (how many and how often)**

Allergies (List all known allergies (drug, food, etc.) and reaction) ❐ No known allergies

____

____

Chronic medical problems/year of onset

	Year		Year	
❐ Heart disease/heart attack		❐ Asthma		❐ Other:
❐ High blood pressure		❐ Allergies/hay fever		
❐ High cholesterol		❐ Vascular disease		
❐ Diabetes		❐ Depression		
❐ Cancer (list type and treatment)		❐ Anxiety		

Prior surgeries and hospitalizations / year

______________________ ______________________

______________________ ______________________

Family history

Please check if any family member has had any of the following conditions: ❐ Unknown ❐ Adopted

Family Member	Good health	Heart disease (Age of onset)	Hypertension (Age of onset)	Stroke (Age of onset)	Cancer (& Type) (Age of onset)	Other Illness (Age of onset)
Father						
Mother						
Sibling						
Grandfather/ Grandmother						
Other:						

guardiant
Health care that empowers

MEDICAL HISTORY FORM (Continued)

Name: ______________________ Date of birth: ______________

Social history

1. Please briefly describe your active/former occupation:
____

2. Please briefly describe your living situation, i.e who lives in your house/apartment and relationship to you:
____

3. Tobacco use: ❒ Never ❒ Current ❒ Former Cigarettes/day: _____ Years used: ______ Year quit: _____
   - If you are currently smoking, are you ready to quit? ❒ Yes ❒ No

4. Alcohol use: ❒ Yes ❒ No ❒ Former Amount: ____________ How often: ___________

5. Exercise/ activity ❒ Yes ❒ No Type: ___________ How often? __________ Hours per week? __________

6. Do you have an advance directive? (These allow a patient to state choices for health care and name someone to make choices if he or she is unable to do so)

❒ None ❒ Advanced Health Care Directive ❒ Physician Orders for Life-Sustaining Treatment ❒ Living Will

Confidential information

Recreational drugs: ❒ No ❒ Yes ❒ Former ❒ Drug Type/Frequency ______________________

Do you have concerns for your safety? ______________________

Preventative medicine

Please list other physicians/health care providers you see (and the reason you see them)

______________________ ______________________

______________________ ______________________

What is your primary concern with your health? ______________________

Please list the last time you received the services below

Health maintenance exam	Year	Immunizations	Year
❒ Mammogram		❒ Tetanus/Whooping cough (Tdap)	
❒ Pap smear		❒ Influenza (Flu)	
❒ Colonoscopy		❒ Shingles (Zostavax)	
❒ Bone density		❒ Pneumonia (Pneumovax)/Prevnar 13	
❒ Eye exam		❒ PPD (Tuberculosis skin test)	
❒ Dental exam		❒ PPD positive ❒ PPD negative	
❒ FloChec		❒ MMR (Measles/mumps/rubella)	
❒ Spirometry			

Do you feel your memory is as good as most? ______________________

Reviewed by: ______________________ **Date:** ______________

Provider's signature