GALEN PRIMARY CARE SOUTHSIDE

MEDICAL HISTORY FORM

NAME _____ BIRTHDATE _____ TODAYS DATE _____

Weight: _____lbs. Height: _____

Reason/s you are seeing the provider today

_____

_____

PHARMACY: (list pharmacy you want to use)
Name _____
Phone _____ Fax: _____
Address _____

Medications Currently Taking (Prescribed and Over the Counter)

MEDICATION NAME/STRENGTH	MEDICATION DIRECTIONS	DATE LAST FILLED	HOW LONG HAVE YOU BEEN TAKING

All Known Allergies/Reactions

ALLERGY	REACTION

PAST MEDICAL HISTORY

Medical Illnesses Diagnosed: (illness/year)

_____ _____

_____ _____

Surgeries: (list all/year)

_____ _____

_____ _____

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NAME/DOB _____

Procedures: (list all/year)
Last Colonoscopy (mm/yy) _____ _____

_____ _____

Preventative History: (list with month/year)
Last Pap (mm/yy) _____ Last Bone Density (mm/yy) _____
Last Mammogram (mm/yy) _____ Eye Exam (mm/yy) _____

Immunizations: (list with month/year)
Influenza (Flu) _____ Shingrix (Shingles) _____
Tdap_____ HepB _____
Covid _____ Other _____
Pneumonia_____

SOCIAL HISTORY

Smoking History
- ☐ Never Smoked
- ☐ New Smoker
- ☐ Current Smoker
- ☐ Previous Smoker

Packs per day _____
# of Years _____

Drinking History
- ☐ NONE
- ☐ Beer
- ☐ Wine
- ☐ Liquor

Drinks/day _____
# of Years _____

Exercise
- ☐ Walking ☐ Jogging
- ☐ Bicycling ☐ Swimming
- ☐ Golf ☐ Tennis
- ☐ Other

Minutes/day _____
Hours/week _____

Recreational Drugs
- ☐ Yes
- ☐ No

Type _____
List Name/Frequency
_____
_____

- Marital Status: (circle) Single Married Widowed Separated Divorced
- Sexually Active: ☐ No ☐ Yes (PLEASE CIRCLE ONE) Men Women Both
- Occupation _____
- Place of Employment _____

FAMILY MEDICAL HISTORY
(PLEASE CHECK ALL THAT APPLY; INCLUDE AGE AT ONSET, IF KNOWN)

	MOTHER	FATHER	GRANDPARENTS /MATERNAL	GRANDPARENTS /PATERNAL	SIBLING
Heart Disease	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
High blood pressure	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Migraine Headaches	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Glaucoma/Cataracts	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Stroke	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Seizure Disorder	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Asthma/Emphysema	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Diabetes	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Thyroid Disorder	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Blood Abnormalities	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Cancer	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Peptic Ulcers	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Mental Illness	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

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REVIEW OF SYSTEMS: Indicate with an **"X"** any of the following problems that pertain to you.

GENERAL	**NOSE**	**GENITOURINARY**	**ENDOCRINE**
☐ Fever	☐ Runny	☐ Sexually active	☐ Hot flashes
☐ Chills	☐ Congestion	☐ Blood in urine	☐ Night sweats
☐ Headaches	☐ Nasal discharge	☐ Frequent nighttime urination	☐ Heat intolerance
☐ Body Aches	☐ Postnasal discharge	☐ Excessive urination	☐ Cold intolerance
☐ Fatigue	☐ Postnasal drip	☐ Frequent urination	☐ Dry skin
☐ Poor appetite	☐ Sinus pressure	☐ Urgency	☐ Hair thining
☐ Weight Loss	☐ Snoring	☐ Incontinent	☐ Other_____
☐ Weight gain	☐ Other _____	☐ Leakage	**HEMOGLOBIN/LYMPH**
☐ Weakness	**MOUTH/THROAT**	☐ Spotting	☐ Blood transfer
☐ Other _____	☐ Sore throat	☐ Heavy periods	☐ Enlarged lymph nodes
PSYCHIATRY	☐ Difficulty swallowing	☐ Irregular periods	☐ Bruising
☐ Depression	☐ Painful swallowing	☐ Vaginal discharge	☐ Bleeding
☐ Anxiety	☐ Dry mouth	☐ Vaginal itching	☐ Other _____
☐ Mood swings	☐ Oral ulcer	☐ Painful intercourse	
☐ Irritability	☐ Hoarseness	☐ Scrotal pain	
☐ Insomnia	☐ White Patches	☐ Penile discharge	
☐ Suicidal	☐ Other_____	☐ Other _____	
☐ Panic attacks	**RESPIRATORY**	**GASTROINTESTINAL**	
☐ Other _____	☐ Cough	☐ Abdominal pain	
SKIN	☐ Shortness of Breath	☐ Pain when swallowing	
☐ Rash	☐ Wheezing	☐ Bloating	
☐ Mole/lesion	☐ Other_____	☐ Cramping	
☐ Skin changes	**CARDIOVASCULAR**	☐ Nausea	
☐ Itching	☐ Chest pain	☐ Vomiting	
☐ Other_____	☐ Rapid heartbeat	☐ Diarrhea	
EYES	☐ Palpitations	☐ Constipation	
☐ Vision changes	☐ Skip beats	☐ Blood in stool	
☐ Blurry vision	☐ PND	☐ Heartburn	
☐ Vision loss	☐ Leg swelling	☐ Belching	
☐ Double vision	☐ Difficulty breathing laying down	☐ Jaundice	
☐ Post nasal drip	☐ Other _____	☐ Bowel incontinence	
EARS		☐ Other _____	
☐ Pain			
☐ Fullness			
☐ Hearing loss			
☐ Ringing			
Other_____			

PLEASE BRING ALL MEDICATIONS AND THIS COMPLETED FORM TO YOUR APPOINTMENT

THANK YOU!