MILLGROVE MEDICAL CENTER
PATIENTS FIRST • FOR ALL YOUR FAMILY HEALTHCARE NEEDS

MEDICAL HISTORY

Name:______________________ **Date of Birth** ______________________ **Date:**____________

Please list ALL MEDICATIONS you are currently taking (including Over-the-Counter, Vitamins, herbs etc

- name______________________ dose______________________
- name______________________ dose______________________
- name______________________ dose______________________
- name______________________ dose______________________

Do you have any ALLERGIES to medications, contrast dyes, or other substances? ______________________

Review of past MEDICAL history (please check all that apply)

☐ Diabetes	☐ Heart Disease	☐ High Cholesterol	☐ High Blood Pressure
☐ Atrial Fibrillation	☐ Stroke	☐ COPD	☐ Asthma
☐ Arthritis	☐ Hepatitis	☐ Glaucoma	☐ Migraines
☐ HIV/Aids	☐ Skin Disease	☐ Seizure disorder	☐ Bleeding disorder
☐ Gout	☐ Anemia	☐ Thyroid disease	☐ Alcoholism
☐ Drug abuse	☐ Sexual dysfunction	☐ Anxiety/depression	☐ Other
Depression			

Review of ROUTINE medical history (please check all that apply)

Mammogram ______________ Date; ______________ Where: ______________
DEXA Scan ______________ Date; ______________ Where: ______________
Eye Exam ______________ Date; ______________ Where: ______________
Colorectal Screening ______________ Date; ______________ Where: ______________

Review of FAMILY history (has any member of the family, siblings, parents, grandparents) ever had the following?

Heart Disease; ______________ member(s); ______________ Age; ________
High Blood Pressure; ______________ member(s); ______________ Age; ________
Diabetes; ______________ member(s); ______________ Age; ________
Stroke; ______________ member(s); ______________ Age; ________
Mental disease (anxiety, depression); ________member(s); ______________ Age; ________
Drug alcohol addiction; ______________ member(s); ______________ Age; ________
Other; ______________ member(s); ______________ Age; ________

Review of SOCIAL history:

Alcohol Yes/No How often? ______________
Cigarette smoking Yes/No How long? ______________
Chew tobacco yes/No How often? ______________
Illicit Drugs Yes/No How often? ______________
Do you exercise Yes/No How often? ______________

Review of IMMUNIZATION history:

Flu vacc? Yes/no when? ______________
Pneumonia vacc? Yes/no when? ______________
Tetanus/ TDap? Yes/no when? ______________
Shingles? Yes/no when? ______________
Meningitis? Yes/no when? ______________

Do you have a Living Will Yes/No?

Other? __________ When? ______________

Review of past SURGICAL history (please list any surgeries you have ever had)

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Who was your previous Primary care doctor?

Name:______________________ Address:______________________ Phone#______________