Memory & Aging Center at

Valley Professionals Community Health Center

Caring Professionals in Your Community.

COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or dates. Thank you!

PERSONAL INFORMATION:

Patient Name: _____ DOB: _____ Date: _____

Current Health Concerns: _____

_____

MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies or Reactions to Medications / Foods / Other Agents: Yes No Please list:

_____

_____

PERSONAL MEDICAL HISTORY: Do you have any of the following? **(Explain below)**

Acid Reflux (heartburn)	Alcoholism	Allergies (environmental)
Anxiety	Asthma	Atrial Fibrillation
Cancer (list below)	Cholesterol Problem	Coagulation (bleeding) Problem
Chronic Low Back Pain	Depression	Diabetes
Heart Disease (explain below)	Grout	High Blood Pressure
Prostate Problems	Migraines	Osteopenia / Osteoporosis
Ulcers	Thyroid Problems	Joint Problems
Eye Problems	COPD	Sleep Apnea

Other Chronic or Recurring Medical Problems:

_____

_____

_____

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Patient Name: _____ Date: _____

SOCIAL HISTORY:

Tobacco Use
Please check one

I have never smoked ☐

I have smoked, but rarely ☐
When was the last time? _____

I have quit smoking. ☐ Quit Date: _____
How many packs/day? _____ How many years? _____

I currently smoke _____pack(s)/day. ☐
How many years? _____

Please circle

Other Tobacco: pipe cigar snuff chew

Are you interested in quitting? Yes No

Socioeconomics
Please circle

Marital Status:

Single Married Separated Divorced Widow

Occupation: _____

Education Completed:

Grade School High School College Graduate School

Number of children: _____

Who lives at home with you?

_____

_____

Alcohol Use
Please circle

Do you drink alcohol? Yes No

Never Occasionally Regularly

Average # drinks/week? 5 oz. wine _____

12 oz. beer _____ 1.5 oz. hard liquor _____

Is alcohol use a concern for you or others? Yes No

Exercise
Please circle

Do you exercise? Yes No

How often do you exercise?

Daily 4-6x/week 1-3x/week Less than 1x/week

What form of exercise? (e.g., jogging, cycling, swimming?)

_____

_____

_____

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Patient Name: _____ Date: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: Yes No (Please list all prior operations and hospitalizations)

Date	Surgery or Hospitalization	Date	Surgery or Hospitalization

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history ☐

Medical Condition	Mom	Dad	Brother	Sister	Daughter	Son	Other Close Relatives
Alcoholism							
Anemia							
Arthritis							
Asthma							
Cancer, Breast							
Cancer, Colon							
Cancer, Prostate							
Cancer, Other (list below)							
Colon Polyps							
Depression							
Diabetes							
Heart Disease (Heart attack, stent or bypass surgery)							
High Blood Pressure							
Kidney Disease							
Strokes							

Other conditions not listed above: _____

_____

_____