

**Mount Vernon Primary Care Associates
Medical History Form**

Name: _____

Date: _____

Date of Birth: _____

Medical

Overnight hospitalizations - medical or surgical (*Please include year*)

Medicines you are currently taking including vitamins & nutritional supplements

Allergies: Please list medication allergies and reaction. Include any allergy to Penicillin, Sulfa, iodine, seafood or dyes.

Please list any past or current medical problems such as diabetes, high blood pressure, heart attacks, skin problems, etc.

Health Maintenance

Please list the last year of your last:

Pap smear _____ Mammogram _____ Flexible sigmoidoscopy _____

Cholesterol test _____ Stool test for blood _____ Colonoscopy _____

Bone density test _____

Immunizations / Vaccinations – Please list year of last:

Tetanus _____ Hepatitis B _____ Flu vaccine _____ Pneumovax _____

Family History

Please list which family members have had the following illnesses:

Cancer _____ High Blood Pressure _____

Diabetes _____ Heart Attacks _____

High Cholesterol _____ Sickle Cell Anemia _____

Breast Cancer _____ Seizures _____

Asthma _____ Strokes _____

Osteoporosis _____

Social History

Occupation: _____

Tobacco Use: How much? _____ Number of years? _____

Caffeine Use: How much? _____

How much alcohol (including beer) do you drink in a week? _____

Are you married, single, divorced, other? _____

Please list the people currently living with you: _____

Do you exercise? _____ How many times a week? _____

Safety

Do you wear a seat belt? _____ Do you own firearms? _____

Do you have smoke alarms in your home? _____ Carbon monoxide detectors? _____

Provider Initials: _____ Date: _____

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Symptom Review

On this page, please check any symptoms that you **CURRENTLY** have with a **C** and any symptoms that have been a problem in the **PAST** with a **P**.

General

Fevers _____
Weight loss/gain _____

Eyes

Vision change _____
Double vision _____
Eye pain _____
Yellow eye _____

Ear, Nose, Throat

Hearing loss _____
Sinus pain _____
Nose bleeds _____
Lump in mouth _____
Seasonal allergies _____

Cardiovascular

Chest pain _____
Palpitations _____
Swelling in legs _____
Irregular heart beat _____
Abnormal EKG _____

Respiratory

Shortness of breath _____
Wheezing _____
Coughing _____
Coughing up blood _____
Pneumonia _____

Gastrointestinal

Trouble swallowing _____
Stomach pain _____
Ulcer _____
Constipation _____
Diarrhea _____
Hemorrhoids _____
Blood in stool _____

Musculoskeletal

Joint pain _____
Muscle weakness _____
Back pain _____
Trouble walking _____

Genitourinary

Kidney stones _____
Blood in urine _____
Urinary tract infections _____
Urinary leakage _____
Increased frequency _____

Skin

Rash _____
Growths _____
Change in mole _____
Warts _____

Neurologic

Headaches _____
Seizure _____
Numbness _____
Stroke _____
Visual Abnormalities _____

Psych

Trouble sleeping _____
Trouble concentrating _____
Depression _____
Feeling "down"/"blue" _____
Marital problems _____
Anxiety _____

Endocrine

Hair loss _____
Feeling hot/cold _____
Excessive thirst _____
Frequent urination _____

Hematologic

Unusual bleeding _____
Unusual bruising _____
Anemia _____
Enlarged lymph nodes _____

Women

Date of last menstrual cycle _____
Irregular menstrual cycle _____
Normal cycle length _____ days
Number of pregnancies: _____
 Live births: _____
 Miscarriages: _____
 Abortions: _____
Last Pap smear _____
Irregular Pap smears _____
Last mammogram: _____
Irregular mammograms _____
Trouble with sex _____
Painful menstrual periods _____

Men

Trouble urinating _____
Trouble starting/stopping
urinary stream _____
Change in urine stream _____
Trouble with erections _____
Trouble with sex _____

Legal

Do you have a living will and/or
power of attorney? _____

Abuse

Have you been a victim of
abuse?
 Physical _____
 Sexual _____
 Emotional _____

Safety

Do you feel safe at home? _____
Do you need community
resources? _____

Provider Initials: _____ Date: _____