PHIPPS FAMILY
— MEDICINE —

Medical History Form

Patient Name: ______________________________ Date of Birth: __________________

Do you have any medication allergies? ☐ Yes ☐ No   If yes, please list allergy and severity:

____

List any medications you are currently prescribed, including supplements & over-the-counter medications:

Medication Name	Dose & Frequency

List all past surgeries and/or procedures along with year performed:

Surgery and/or Procedure Name	Year Performed

List any pertinent family history: Please check here for unknown family history ☐

Father	☐ Alive ☐ Deceased	Cause of death:
Mother	☐ Alive ☐ Deceased	Cause of death:
Sibling	☐ Alive ☐ Deceased	Cause of death:

List any additional information: ____

Past Medical History (check.all.that.apply)

☐ Head Trauma	☐ Goiter	☐ Hypo/Hyper Thyroidism
☐ Type 1 Diabetes	☐ Type 2 Diabetes	☐ Blindness
☐ Cataracts	☐ Glaucoma	☐ Wears glasses/ contacts
☐ Hearing Aids	☐ Cancer (list details):	☐ Allergic Rhinitis
☐ Sinus Infections	☐ HIV	☐ STDs
☐ Tuberculosis	☐ Dentures	☐ Arthritis
☐ Gout	☐ Aneurysm	☐ Angina
☐ DVT	☐ Dysrhythmia	☐ High Blood Pressure
☐ Murmur	☐ Heart Attack	☐ Dermatitis
☐ Mole	☐ Acne	☐ Psoriasis
☐ Asthma	☐ Bronchitis	☐ COPD
☐ Pneumonia	☐ Epilepsy	☐ Seizures
☐ Migraines	☐ Stroke	☐ TIA
☐ Cirrhosis	☐ GERD	☐ Heartburn
☐ Hemorrhoids	☐ Hepatitis	☐ Jaundice
☐ Ulcer	☐ Bipolar Disorder	☐ Depression
☐ Suicidal Ideations/ Attempts	☐ Incontinence	☐ Kidney Stone

Medical History Form

Social History (check.all.that.apply)

Tobacco:

☐ Current everyday smoker ☐ Current some smoker ☐ Former smoker ☐ Heavy smoker
☐ Light smoker ☐ Never smoked ☐ Smokeless tobacco ☐ Vape pen

Alcohol:

☐ Do not drink ☐ Drink daily ☐ Occasional drink ☐ History of alcoholism

Drug Abuse:

☐ Intravenous drug use ☐ illicit drug use ☐ No illicit drug use

Lifestyle:

☐ Eat healthy meals ☐ Regular exercise ☐ Take daily aspirin

Sexual Activity:

☐ Not sexually active ☐ Sexually active ☐ Safe sex practices

Birth Gender:

☐ Male ☐ Female ☐ Undifferentiated

Health Maintenance Screening Test History

Screening Test Name	Date:	Facility/ Provider:	Abnormal Result?
Comprehensive Physical Exam			☐ Y ☐ N
Colonoscopy/ Cologuard			☐ Y ☐ N
Mammogram			☐ Y ☐ N
Pap Smear			☐ Y ☐ N
Bone Density			☐ Y ☐ N