Parker Square Family Practice MEDICAL HISTORY	*DATE:*
PATIENT NAME:	*DOB:*

List all current medications

_____ _____

_____ _____

_____ _____

List all Hospitalizations/Surgeries	YEAR	ILLNESS OR SURGERY

List all Allergies

1._____ 2. _____

3. 4.

Family History

Designate any family member who has been diagnosed with the following conditions using (M) Mother, (F) Father, (S) Sibling, (GM) Grandmother, and (GF) Grandfather.

_____ Epilepsy	_____ Thyroid Disease	_____ Osteoporosis	_____Lipid Disorder
_____ Migraine	_____ Heart Disease	_____ Mental Illness	_____ Alcoholism
_____ Hayfever	_____ Hypertension	_____ Arthritis	_____ Bleeds Easily
_____ Asthma	_____ Glaucoma	_____Anemia	_____ Stroke
_____ Diabetes	_____ Cancer - Type of cancer: _____		

Main Health Problems	1.	2.	3.

Medical History: Please check the box next to each symptom or disease you have been diagnosed with in the past.

Eyes/Ears/Nose/Throat
- ☐ Decreased Hearing
- ☐ Ringing in ear
- ☐ Frequent ear infections
- ☐ Dizzy Spells
- ☐ Failing vision
- ☐ Eye Pain
- ☐ Double or blurred vision
- ☐ Frequent eye infections
- ☐ Recurrent nose bleeds
- ☐ Sinus trouble
- ☐ Frequent sore throats
- ☐ Hayfever/Seasonal allergies

Pulmonary
- ☐ Pneumonia/Pleurisy
- ☐ Bronchitis/Chronic cough
- ☐ Asthma/Wheezing
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath laying flat

Cardiology
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Irregular pulse
- ☐ Swollen legs/ankles
- ☐ Leg pain—when walking
- ☐ Rheumatic Fever
- ☐ Scarlet Fever

Endocrinology
- ☐ Thyroid disease
- ☐ Diabetes

Gastroenterology
- ☐ Recent loss of appetite
- ☐ Difficulty swallowing
- ☐ Heart Burn
- ☐ Peptic ulcer
- ☐ Persistent Nausea/Vomiting
- ☐ Chronic Abdominal pain
- ☐ Gall bladder trouble
- ☐ Jaundice/Hepatitis
- ☐ Diverticulitis
- ☐ Chron's/Colitis
- ☐ Hemorrhoids
- ☐ Hernia

Urology
- ☐ Frequent urine infections
- ☐ Kidney Stones
- ☐ Uerthral discharge

Hematology
- ☐ Chronic Fatigue
- ☐ Anemia
- ☐ Bruise easily

Oncology
- ☐ Cancer _____

Neurology
- ☐ Seizures
- ☐ Tremor/Hands shaking
- ☐ Muscle weakness
- ☐ Numbness/Tingling
- ☐ Stroke
- ☐ Frequent headaches
- ☐ Cold numb feet
- ☐ Fainting Spells

Musculoskeletal
- ☐ Recurrent back pain
- ☐ Bone fracture/joint injury
- ☐ Gout
- ☐ Osteoporosis
- ☐ Foot pain
- ☐ Arthritis/Rheumatism

Psychology
- ☐ Sleeping difficulty
- ☐ Concentration difficulty
- ☐ Depression
- ☐ Nervousness
- ☐ Memory loss
- ☐ Moodiness
- ☐ Suicidal thoughts

Dermatology
- ☐ Eczema
- ☐ Psoriasis

Other not listed: _____

FEMALES: please complete

Menstrual Flow:
☐ Regular ☐ Irregular ☐ Painful
Days of flow _____
Length of cycle _____

During sex: ☐ Pain ☐ Bleeding ☐ Normal
After sex: ☐ Pain ☐ Bleeding ☐ Normal

Number of :
Pregnancies _____
Abortions _____
Miscarriages _____
Live births _____

Birth Control Method:
Pill (name) _____
Other: _____

☐ Flushing/Menopause

Date of last Pap: _____
☐ Normal ☐ Abnormal
Date of last Mammogram:_____
☐ Normal ☐ Abnormal

MALES: Please complete:
- ☐ Prostate problems
- ☐ Erectile dysfunction
- ☐ Testicular Lumps/Pain
- ☐ Testosterone Deficiency