

Rocky Creek Family Medicine

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MEDICAL HISTORY FORM

Date: _____ Name: _____ DOB: _____ SEX: M / F

Allergies to Medications: _____

List of Medications: _____

YOUR MEDICAL HISTORY: (CIRCLE ANY DIAGNOSIS YOU HAVE OR HAVE HAD IN THE PAST)

Diabetes Mellitus	Migraine	Anemia
Hypertension	Mental Illness (Depression, Anxiety, Etc.)	
CVA (Stroke)	Thyroid disease	Kidney Stones
CAD (Heart Disease)	Glaucoma	GERD (Reflux)
CHF (Heart Failure)	Gout	Ulcers (Peptic)
Allergic Rhinitis	Arthritis	Gallbladder
Epilepsy	Vision Problems	Heart Murmur
Cancer (Type?): _____	Other: _____	

SURGICAL HISTORY: Appendectomy Gallbladder Hysterectomy
 Obesity Surgery Other: _____

HOSPITALIZATION: _____

FAMILY HISTORY: (LIST MEDICAL PROBLEMS IN THESE RELATIVES)

Mother: _____ Father: _____

Brother(s)/Sister(s): _____

Paternal Grandparents (Dad's Parents): _____

Maternal Grandparents (Mom's Parents): _____

Uncle(s)/Aunt(s): _____ Other: _____

SOCIAL HISTORY: Occupation: _____ Marital Status: S M D W

Tobacco Use/Smoking: _____ pack(s)/day Second hand smoke: Y / N

Alcohol: _____ oz per week Caffeine intake(circle): Coffee/Tea/Soda _____ cups/day

Use of recreational/street drugs: Y / N If yes, what type: _____

Do you have pets: Y / N If yes, what type: _____