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: _____