EAST NORTHPORT MEDICAL CARE

MEDICAL HISTORY FORM

Patient Name:______________________________________ Date of Birth:_______________________

PLEASE FULLY COMPLETE THIS FORM: Your answers will help your provider understand your medical concerns and conditions better.

REASON FOR TODAY'S VISIT:

____

ALLERGIES and/or REACTIONS TO MEDICINES:

____

CURRENT MEDICATIONS: Prescription, non-prescription medicines, vitamins, and supplements.

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PERSONAL MEDICAL HISTORY: Do you or have you had any of these problems?

Irregular Heart Beat_____________________	Kidney Stones______________________________
Congestive heart Failure_________________	Kidney Disease/Infections____________________
Blood Clot_____________________________	Breast Disease______________________________
High Cholesterol________________________	Fracture, which bone(s):______________________
High Blood Pressure_____________________	Arthritis_____________________________________
Heart Attack___________________________	Gout____
Heart Murmur__________________________	Stroke_______________________________________
Asthma_________________________________	Dementia_____________________________________
Skin disease, Type:______________________	Cancer, Type:_________________________________
Pneumonia_____________________________	HIV____
Pulmonary Embolism_____________________	STDs____
Tuberculosis____________________________	Blood Transfusion______________________________
Sleep Apnea____________________________	Anemia_______________________________________
Gall Stones____________________________	Bleeding Disorder______________________________
Liver Disease/Hepatitis___________________	Seasonal Allergies_____________________________
Hemorrhoids____________________________	Emphysema/Chronic Bronchitis____________________
Diabetes Type 1 (Childhood onset)__________	Stomach Ulcer________________________________
Diabetes Type 2 (Adult onset)_____________	Problems During Pregnancy____________________
Diverticulitis___________________________	Thyroid Disease (High/Low)____________________
Ulcerative Colitis/ Crohn's_______________	Depression____________________________________
Heart Burn/ Reflux_______________________	Anxiety______________________________________

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Patient Name:____________________________________ Date of Birth:______________________

Please indicate Family History: Mother, Father, Sister, Brother, Grandmother, Grandfather

Alcoholism_______________________
Anemia_________________________
Anesthesia problem_________________
Arthritis_____________________________
Asthma_____________________________
Autoimmune disorder_________________
Bleeding problem_____________________
Cancer, breast_________________________
Cancer, colon__________________________
Cancer, melanoma______________________
Cancer, ovary__________________________
Cancer, prostate_________________________
Heart attack _________________________________
Birth defects__________________________________
Depression___________________________________
Diabetes, type 1 _________________________
Diabetes, type 2______________________________
Eczema____
Food Allergies_________________________________
Other genetic disease___________________
Hay fever_________________________________
Hearing problems_________________________
High cholesterol_____________________________
(Hyperlipidemia)_____________________________
High blood pressure__________________________
Immunosuppressive disorders____________________
Kidney disease______________________________
Mental Retardation____________________________
Osteoporosis_________________________________
Epilepsy____________________________________
(seizure disorder)_____________________________
Stroke____
Substance abuse______________________________
Thyroid disorders______________________________
Smoking______________________________________
Tuberculosis__________________________________

____ ____________________
Patient's Signature Date