Wilson Medical Group
HISTORY FORM

Patient Name: _____Date: _____

Please check all that you have a history of:

0 Allergy	0 Eye Disease	0 Hepatitis	0 Thyroid Disorder
0 Asthma	0 Hearing Disorder	0 Incontinence	-hypo/hyper
0 COPD	0 Cancer	0 GERD (reflux)	0 Depression
0 Pneumonia	- Type_____	0 Irritable Bowel Syn	0 Anxiety
0 High Blood Pressure	0 Seizures	0 Diabetes	0 Mental Illness:
0 High Cholesterol	0 Migraines	0 Eczema/psoriasis	-type_____
0 Heart Attack	0 Stroke	0 HIV	0 Fibromyalgia
0 Heart Murmur	0 Neck/Back Pain	0 Anemia	0 Other
0 Artificial Heart Valve	0 Osteoporosis	0 Bleeding Disorder	_____
0 Atrial Fibrillation	0 Kidney Disease	0 Blood Clot	_____

Please list all <u>Surgeries</u> and <u>Date</u> of surgery:

_____ _____
_____ _____
_____ _____
_____ _____

Please list all doctors you currently see:

1_____
2_____
3_____
4_____

FAMILY HISTORY

Father**:** Date of Birth_____ Living Yes or No If deceased, age at death: _____
List any medical conditions: _____
_____

Mother: Date of Birth_____ Living Yes or No If deceased, age at death: _____
List any medical conditions: _____
_____

Brothers**:** Number Living _____ Number Deceased _____ If deceased age at death: _____
List any medical conditions: _____

Sisters**:** Number Living _____ Number Deceased _____ If deceased age at death: _____
List any medical conditions: _____

Sons**:** Number Living _____ Number Deceased _____ If deceased age at death: _____
List any medical conditions: _____

Daughters**:** Number Living _____ Number Deceased _____ If deceased age at death: _____
List any medical conditions: _____

****PLEASE SEE OTHER SIDE****

SOCIAL HISTORY

Marital Status: (circle one) Single Married Widowed Divorced
Do you use alcohol: Yes or No If yes, how many drinks per week? _____
Do you smoke? Yes or No -If yes, how much per day?_____ Age started____ Age quit____
Employment Status (circle one) working retired unemployed disabled
Occupation _____

IMMUNIZATIONS/VACCINATION/SCREENING TESTS

(Please list date of your last)

Tetanus shot _____ Colonoscopy _____
Pneumonia vaccine _____ PSA/prostate exam _____
Shingles vaccine _____ Eye exam _____
Gardasil/HPV vaccine _____ Cholesterol check _____
Hepatitis B vaccine _____ Stress test _____
Flu shot _____ Bone density _____
Whooping cough vaccine _____ Diabetic foot exam _____
PPD _____ Sleep study _____

REVIEW OF SYMPTOMS

(Please circle any of the following that you are concerned about)

weight loss/gain
fevers
headaches
rash
itching
hives
congestion
ear pain
sore throat
chest pain
leg swelling
palpitations
cough
wheezing
shortness of breath
nausea
diarrhea
abdominal pain
urinary frequency
incontinence
burning with urination
vaginal discharge
irregular periods
erectile dysfunction
joint pain
muscle spasm/pain
neck/back pain
heat/cold intolerance
seizures
numbness
dizziness
depression
anxiety
trouble sleeping

ADVANCE DIRECTIVES

Do you have a Living will? (circle one) Yes or No
Do you have Power of Attorney for health care (circle one) Yes or No
- If Yes: (Name/Phone#) _____