Marion Wellness & Disease Management, PLLC | 59 Gypsy Mountain Rd Marion, NC 28752 | Office (828) 652-8196 | Fax (828) 652-8186

# PATIENT HEALTH HISTORY: HIGHLIGHTED AREAS REQUIRED

**NAME:** ____________________________________________ **AGE:** _______ **Today's Date:** ______________________________

## MEDICAL HISTORY & FAMILY MEDICAL HISTORY

Please write **NOW** or **PAST** for your significant medical history AND **WHICH FAMILY MEMBER**

(Example: Mom, Dad, Sis, Bro, M-GM, M-GF, P-GM, P-GF, M-aunt, P-aunt, P-aunt, P-uncle, Son, Daughter)

| | SELF | FAMILY MEMBER | | SELF | FAMILY MEMBER | | SELF | FAMILY MEMBER |
|---|---|---|---|---|---|---|---|---|
| **Example** | **NOW** | | **Example** | **PAST** | **M-GF** | **Example** | | **Sis.** |
| Loss of hearing | | | Hemorrhoids | | | Depression | | |
| Ringing in ears | | | Hernia | | | Suicidal thoughts | | |
| Frequent ear infections | | | Gall bladder problems | | | Other mental illness | | |
| Vision problems | | | Nausea | | | Urination Problems | | |
| Glaucoma | | | Vomiting | | | Frequent urination | | |
| Nose bleeds | | | Sudden weight loss/gain | | | Kidney stones | | |
| Chronic sinus trouble | | | Liver disease | | | Kidney disease | | |
| Frequent sore throat | | | Hepatitis | | | Cancer- Breast | | |
| Significant Allergies | | | High cholesterol | | | Cancer- Colon | | |
| Hoarseness | | | Diabetes | | | Cancer- Lung | | |
| Pneumonia | | | Hypoglycemia | | | Cancer- Prostate | | |
| Chronic bronchitis | | | Thyroid disease | | | Cancer- Ovarian | | |
| Asthma | | | Bleeding/clotting disorder | | | Cancer- Skin | | |
| Shortness of breath | | | Osteoporosis | | | Cancer- Other | | |
| Tuberculosis | | | Leg cramps | | | Polio | | |
| Heart murmur | | | Joint Pain | | | Mumps/Measles | | |
| Palpitations | | | Arthritis | | | Chicken Pox | | |
| Irregular heart beat | | | Back pain | | | STI/STD: | | |
| Swollen ankles | | | Broken bones | | | OTHER: | | |
| Chest pain | | | Gout | | | | | |
| High blood pressure | | | Rashes | | | | | |
| Heart Attack | | | Skin changes | | | | | |
| Stroke | | | Varicose veins | | | | | |
| Anemia | | | Dizzy spells | | | | | |
| Trouble swallowing | | | Fainting spells | | | | | |
| Indigestion/Heartburn | | | Memory loss | | | | | |
| Reflux/GERD | | | Seizures/Epilepsy | | | | | |
| Stomach ulcer | | | Migraines / Headaches | | | | | |
| Chronic Diarrhea | | | Fatigue | | | | | |
| Constipation | | | Problems with sleep | | | | | |
| Bloody/tarry stools | | | Nervous / Anxious | | | | | |

**Alcohol use**, NEVER / PAST / CURRENT:

___Drinks Yearly
___Drinks Monthly
___Drinks Weekly
___Drinks Daily
Type of alcohol used: ________________

**Tobacco use**, NEVER / PAST / CURRENT:

Type of tobacco used: ________________
How much: ________________________
For how many years? ________________

**Illegal Drugs**, NEVER / PAST / CURRENT:

Type of drug used: __________________
How much: ________________________
Last use: _________________________

**MEN ONLY**

Changes in urine stream? **YES NO**
Prostate problems? **YES NO**
Pain/Lump in Testicle? **YES NO**
Pain or problems with sex? **YES NO**
Monthly Testicular Self-Exam? **YES NO**
**Other Problems** _________________________

**WOMEN ONLY**

Last period _______________Regular / Irregular
Birth Control Method ______________________
Abnormal Bleeding? **YES NO**
Pain or problems with sex? **YES NO**
Monthly Breast Self-Exam? **YES NO**
**Other Problems** _________________________

Anything not listed above or comments you would like to add about yours or your family members health: ___________________________________

## SURGICAL / HOSPITAL HISTORY

Please list any illness/operations you've had that required a stay in the hospital (not including pregnancies)

| YEAR | Illness / Operation and Hospital Name | YEAR | Illness / Operation and Hospital Name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

OVER, PLEASE

**PATIENT HEALTH HISTORY** *(continued)* HIGHLIGHTED AREAS REQUIRED

## PREVENTATIVE CARE

Please list the year last done and circle if normal or abnormal

| Test | Year | Result (Please Circle) | Test | Year | Result (Please Circle) |
|---|---|---|---|---|---|
| Vision Exam (by eye doctor) | | Normal / Abnormal | Women: Pelvic / Pap | | Normal / Abnormal |
| Dental exam / cleaning | | Normal / Abnormal | Bone Density Scan | | Normal / Abnormal |
| Colonoscopy | | Normal / Abnormal | Endoscopy | | Normal / Abnormal |
| Women (age 40+): Mammogram | | Normal / Abnormal | Men (age 40+): Prostate exam | | Normal / Abnormal |

| | |
|---|---|
| **When was your last checkup at a doctors office?** | **When was the last time you had blood work completed?** |
| What year was your last Tetanus Shot ______, Tdap or Td? | Have you had a pneumonia shot as an adult? **YES NO** |
| Have you had a shingles shot? **YES NO** | When was your last Flu Shot? ______. |

## MEDICATIONS

Please list **all** medication you are now taking

**including over the counter medications, vitamins, herbs and other supplements

| | |
|---|---|
| Preferred Pharamcy | Located in (City) |
| Additional/Alternate Pharamcy | Located in (City) |

I prefer a ▫ **90-day** (3 month) or ▫ **30-day** (1 month) supply of my daily prescription medication(s)

| Medication Name | Strength | Frequency | Reason taking |
|---|---|---|---|
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By signing below, I agree that the information I am providing is accurate and up-to-date to the best of my knowledge AND I will update Marion Wellness & Disease Management, PLLC of any changes as soon as possible

Signature: ______________________________ Today's Date: ____________________