

MIDDLETOWN FAMILYCARE ASSOCIATES

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PATIENT HISTORY

Today's Date: _____

Male/Female (Please circle) _____

Date of Birth: _____

Name: _____		Occupation: _____	
Pharmacy Name: _____		Location: _____	
Pharmacy Phone #: _____		_____	
Family History: (If any blood relative has suffered any of the following- please circle the number and indicate which relative)			
1) Epilepsy	6) Thyroid Disease	11) Osteoporosis	16) Lipid Disorder
2) Migraines	7) Hayfever/Allergy	12) Arthritis	17) Alcoholism
3) Alzheimers	8) Asthma	13) Heart Disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds Easily	15) Hypertension	20) Depression/Mental Health
Hospital Admissions	Year	Illness or Operation	Year
(Do not include Pregnancies)			
List all Medications you are now taking:		Allergies:	Vaccines: Year of Last
			Test/Exam: Year of Last
			Tetanus /Td -
			Flu Shot -
			Pneumonia -
			Hepatitis -
			T.B.- PPD -
			Rectal/Prostate -
			Cholesterol -
			Eye -
			Mammogram:
			Pap:
MEDICAL HISTORY: Mark (C) for current problems. Check and indicate age when you had any of the following symptoms/diseases			
Main Problems:	1.	2.	3.
<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Rheum Fever <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Weight loss <input type="checkbox"/> Gain- recent	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio
<input type="checkbox"/> Ear Infections - frequent	<input type="checkbox"/> Loss of appetite - recent	<input type="checkbox"/> Cancer <input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Mumps
<input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Measles <input type="checkbox"/> German Measles
<input type="checkbox"/> Failing vision <input type="checkbox"/> Eye Pain	<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes
<input type="checkbox"/> Double or blurred vision	<input type="checkbox"/> Persistent nausea / Vomiting	<input type="checkbox"/> Tremor hands/shaking	<input type="checkbox"/> Aids / HIV
<input type="checkbox"/> Nose bleeds - recurrent	<input type="checkbox"/> Abdominal pain - chronic	<input type="checkbox"/> Numbness / tingling sensations	<input type="checkbox"/> Alcohol _____ oz. Per week
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Headaches - frequent	<input type="checkbox"/> Coffee/Tea _____ cups per day
<input type="checkbox"/> Soar throats - frequent	<input type="checkbox"/> Jaundice / Hepatitis	<input type="checkbox"/> Arthritis / Rheumatism	<input type="checkbox"/> Smoking _____ cig/day
<input type="checkbox"/> Hoarseness - prolonged	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Back Pain - recurrent	<input type="checkbox"/> #yrs year quit
<input type="checkbox"/> Hayfever / Allergies	<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis	<input type="checkbox"/> Bone fracture / joint injury	<input type="checkbox"/> Exercise - _____
<input type="checkbox"/> Pneumonia / Pleurisy	<input type="checkbox"/> Bloody or tarry stools	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Street Drugs
<input type="checkbox"/> Bronchitis / Chronic cough	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia	<input type="checkbox"/> Foot pain <input type="checkbox"/> Gout	<input type="checkbox"/> Accupuncture / tattoos
<input type="checkbox"/> Asthma / Wheezing	<input type="checkbox"/> Urination - Overactive bladder	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives	Hair loss: <input type="checkbox"/> Progressive <input type="checkbox"/> recent
<input type="checkbox"/> Shortness of Breath: <input type="checkbox"/> on exertion <input type="checkbox"/> lying flat	<input type="checkbox"/> Overnight >than twice	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	COMPLETE Menstrual flow:
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> More than 8 times/24 hrs.	Mental Health:	<input type="checkbox"/> Reg. <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/cramps
<input type="checkbox"/> High blood pressure -	<input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage	<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness	Days of Flow _____ lngth of cycle _____
<input type="checkbox"/> Heart Murmur <input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Decrease in force/flow	<input type="checkbox"/> Sleeping or Concentration difficulty	Date (1 st) day of last period _____
<input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations	<input type="checkbox"/> Painful	<input type="checkbox"/> Agitation <input type="checkbox"/> Memory Loss	<input type="checkbox"/> Pain or bleeding during of after sex
<input type="checkbox"/> Leg pain - when walking	<input type="checkbox"/> Stress incontinence-urine leakage w/exercise/movement	<input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts	Number of: Pregnancies _____
<input type="checkbox"/> Varicose veins / Phlebitis	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness	Abortions _____
<input type="checkbox"/> Cold numb feet	<input type="checkbox"/> Urine infections - frequent	<input type="checkbox"/> Feelings of worthlessness	Miscarriages _____ Live Births _____
	<input type="checkbox"/> Kidney stones		Birth control method _____
			B.C. pill (name) _____
			Other: _____
			Other: _____