FLOWER MOUND
FAMILY PHYSICIANS

MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

Reasons for visit: _____

Previous PCP: _____ Preferred Pharmacy: _____

List all Current Prescription Medications Only:

Medication/Dosage	Directions	Prescribing Dr.

➢ Drug Allergies

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Iodine ☐ Metal ☐ Latex ☐ Iodine ☐ Acrylic

☐ Other If yes, please explain _____

_____

➢ Medical History

Do you have, or have you had, any of the following?

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ COPD
☐ Congestive Heart Failure
☐ Crohn's Disease
☐ Depression
☐ Diabetes
☐ Endocrine Problems
☐ GERD
☐ Glaucoma
☐ Hypertension
☐ HIV/ AIDS
☐ Kidney Disease
☐ Myocardial Infarction
☐ Stroke
☐ Ulcerative Colitis

☐ Other If yes, please explain _____

_____

➢ Surgical History

Check box if yes, provide date beside it

☐ Appendectomy --	☐ CABG --	☐ Prostate Surgery --
☐ Bladder Surgery --	☐ Gastric Bypass Surgery --	☐ Pacemaker --
☐ Bariatric Surgery --	☐ Hemorrhoid Surgery --	☐ Spine Surgery --
☐ Breast Surgery --	☐ Hernia Repair --	☐ Stomach Surgery --
☐ Cesarean Section --	☐ Hysterectomy --	☐ Angioplasty or Stent --
☐ Cholecystectomy --	☐ Joint Replacement -Knee/Hip -	☐ Thyroids Surgery --
☐ Colon Surgery --	☐ Kidney Surgery --	☐ Tonsillectomy --

☐ Other _____

_____

➢ Family Medical History:

Father: Living, age: _____ Deceased, age at death: _____ Cause: _____

Mother: Living, age: _____ Deceased, age at death: _____ Cause: _____

Siblings: Number Living: _____ Number Deceased: _____ Cause: _____

Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

☐ Cancer/Polyps_____ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma	☐ Anemia ---	☐ High Blood Pressure ---
	☐ Diabetes ---	☐ Anesthesia Reaction ---
	☐ Blood Clots ---	☐ Bleeding Problems ---
	☐ Heart Disease ---	☐ Hepatitis ---
	☐ Stroke ---	

☐ Other _____

_____

➢ Preventive Tests and Date (Mm/Yr)

☐ Last Physical Exam_____ ☐ Mammogram _____

☐ Last Pap smear_____ ☐ Bone Density _____

☐ Date of last period _____ ☐ Colonoscopy _____

☐ Diabetic eye exam_____ ☐ Upper Endoscopy_____

➢ Social history

Currently Smoking? (check box if yes) ☐ Cigarettes ☐ Cigar ☐ Vaping ☐ Chewing Tobacco

How many years? _____ Amount per day? _____ Attempts to quit? _____

Previous Smoking: How many years? _____ Amount per day? _____

Alcohol Intake - ☐ Never ☐ Occasionally ☐ Daily Type _____

➢ Immunizations and Date

☐ HPV_____ ☐ Meningococcal _____ ☐ RSV _____

☐ TDAP_____ ☐ Preumovax _____ ☐ Shingrix _____

Other _____