

MacGregor Medical Center

Social Security Number: _____

Date: _____

Date of Birth: ____/____/____

Name: _____

Current Occupation: _____

Employer: _____

Street Address _____ City _____ State _____ Zip _____

Home Phone: _____

Work Phone: _____

If you have a spouse, name: _____

Emergency Contact: _____ (Emergency Contact Phone): _____

Marital Status: Single _____ Married _____ Divorced _____ Widow(er) _____

Do you have a Living Will? Y___N___ A Durable Power of Attorney for health care? Y___N___

If so, where is it filed? _____

Who is your primary care doctor now? _____ Who was your previous doctor? _____

Comments: _____

FAMILY HISTORY

Age(s) (or) age(s) at death

Medical Problems

*Any immediate family members
with the following?:*

Father: (Alive? Y___N___) _____

Mother: (Alive? Y___N___) _____

Brothers: (total number ___ number alive ___) _____

Sisters: (total number ___ number alive ___) _____

Children: (how many? ___) _____

Migraines Y___ N___

Glaucoma Y___ N___

Gout Y___ N___

High Cholesterol Y___ N___

Kidney Disease Y___ N___

Thyroid Disease Y___ N___

Breast Cancer Y___ N___

Prostate Cancer Y___ N___

Tuberculosis Y___ N___

Osteoporosis Y___ N___

Alcoholism Y___ N___

Any myocardial infarction (MI, heart attack) in your family before age 65? Y___ N___

Any unusual or rare diseases in your family? _____

Any other family history we should know? _____

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**ALLERGIES** or side effects from medications (list name of medication/type of reaction):  
\_\_\_\_\_

## IMMUNIZATIONS

When was your last: Tetanus shot (estimated): \_\_\_\_\_(year) Influenza vaccine (flu shot): \_\_\_\_\_(year)

Have you had: Pneumococcal (pneumonia) vaccine: Y\_\_\_ N\_\_\_ Year \_\_\_\_\_

Hepatitis B vaccine? Y\_\_\_ N\_\_\_ Year \_\_\_\_\_ Hepatitis A vaccine? Y\_\_\_ N\_\_\_ Year \_\_\_\_\_

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**PERSONAL HISTORY**

|                                                        |                    |                                             |                             |                     |                                  |
|--------------------------------------------------------|--------------------|---------------------------------------------|-----------------------------|---------------------|----------------------------------|
|                                                        |                    | <u>amount</u>                               | <u>type (circle)</u>        | <u>year started</u> | <u>year stopped (if stopped)</u> |
| Tobacco, ever:                                         | Y_____ N_____      | _____ per day                               | cigarettes/pipe/snuff       | _____               | _____                            |
| Alcohol:                                               | Y_____ N_____      | _____ per day/wk/mo                         | beer/wine/other             | _____               | _____                            |
| Drugs (recreational)                                   | Y_____ N_____      | _____ per day                               | marijuana or:_____          | _____               | _____                            |
| Sexually active?                                       | Y_____ N_____      | How many partners(s) in the past year?_____ | Sex partners are: Male_____ | Female_____         |                                  |
| Your height:_____                                      | Usual weight:_____ |                                             |                             |                     |                                  |
| What weight change have you had in the past year?_____ |                    |                                             |                             |                     |                                  |

**MEDICATIONS:** (Please include birth control pills and any over-the-counter, nonprescription drugs!)

|          |            |               |          |            |               |
|----------|------------|---------------|----------|------------|---------------|
| Name     | dosage(mg) | times per day | Name     | dosage(mg) | times per day |
| 1. _____ |            |               | 5. _____ |            |               |
| 2. _____ |            |               | 6. _____ |            |               |
| 3. _____ |            |               | 7. _____ |            |               |
| 4. _____ |            |               | 8. _____ |            |               |

**Hospitalizations and Surgeries**

|             |             |
|-------------|-------------|
| <u>Year</u> | <u>Year</u> |
| 1. _____    | 5. _____    |
| 2. _____    | 6. _____    |
| 3. _____    | 7. _____    |
| 4. _____    | 8. _____    |

**Major illnesses or injuries:** \_\_\_\_\_

**HEALTH MAINTENANCE**

Is your cholesterol high (over 200) Y\_\_\_\_\_ N\_\_\_\_\_ Unknown\_\_\_\_\_ When?\_\_\_\_\_ Result? \_\_\_\_\_

Have you ever had stool tests for blood? Y\_\_\_\_\_ N\_\_\_\_\_ Unknown\_\_\_\_\_ When?\_\_\_\_\_ Result? \_\_\_\_\_

Have you had a sigmoidoscopy? Y\_\_\_\_\_ N\_\_\_\_\_ Unknown\_\_\_\_\_ When?\_\_\_\_\_ Result? \_\_\_\_\_

Do you use a seat belt each time you drive? Y\_\_\_\_\_ N\_\_\_\_\_

Hobbies or physical activities: \_\_\_\_\_

**Men:**

Last prostate exam (month/year): \_\_\_\_\_ Have you had a prostate blood test (PSA)? Y\_\_\_\_\_ N\_\_\_\_\_ Unknown \_\_\_\_\_

Do you examine your testicles regularly? Y\_\_\_\_\_ N\_\_\_\_\_ How often? \_\_\_\_\_

**Women:**

Age on onset of periods: \_\_\_\_\_ Last menstrual period (first day): \_\_\_\_\_

Last Pap Smear (month/year): \_\_\_\_\_ Last mammogram (month/year): \_\_\_\_\_

How often do you examine your breasts? \_\_\_\_\_

Do you have a gynecologist? Y\_\_\_\_\_ N\_\_\_\_\_ Who? \_\_\_\_\_

Number of times pregnant? \_\_\_\_\_ Number of abortions? \_\_\_\_\_

Number of live births: \_\_\_\_\_ Number of miscarriages \_\_\_\_\_

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# REVIEW OF SYSTEMS

Please place a check (✓) in each box for every "yes" answer to the following questions. Use the space on the back of this form to write in any explanations or other information you would like us to know. Have you had any of the following conditions or medical problems?

## A. Constitutional

1. Weight loss (recent)
2. Weight gain (recent)
3. Fevers or chills (recent)
4. Loss of appetite
5. Unusual fatigue
6. Sleeping difficulty
7. Drenching night sweats

## B. Eyes

1. Double vision
2. Failing vision
3. Red eyes
4. Eye pain
5. Glaucoma
6. Cataracts

## C. Ears, Nose, Throat

1. Decreased hearing
2. Ringing in the ears
3. Frequent ear infections
4. Vertigo or dizziness
5. Snoring
6. Nosebleeds (recent)
7. Sinus disease
8. Problems with teeth
9. Gum pain or bleeding
10. Hoarseness
11. Speech problems

## D. Respiratory

1. Constant cough
2. If yes, any sputum?
3. Pneumonia
4. Bronchitis
5. Asthma
6. Wheezing
7. Tuberculosis (Tb)
8. Positive skin test, Tb
9. Pleurisy
10. Emphysema

## E. Heart/Blood Vessels

1. Chest pain or tightness

2. Short breath - activity
3. Short breath - lying flat
4. Swelling of the feet
5. Palpitations
6. Heart murmur
7. Rheumatic fever
8. High blood pressure
9. High cholesterol
10. Heart attack (M.I.)
11. Heart failure
12. Fainting
13. Calf pain, walking
14. Phlebitis

## F. Gastrointestinal

1. Difficulty swallowing
2. Nausea, vomiting
3. Hepatitis
4. Pancreatitis
5. Stomach/ulcer
6. Pain/abdomen (recent)
7. Bright red blood/stool
8. Black or tarry stool
9. Diarrhea
10. Constipation
11. Recent change in bowel habits
12. Bloating
13. Colon polyps
14. Hemorrhoids
15. Hernia
16. Irritable bowel/spastic colon

## G. Genital/Urinary

1. Kidney disease
  2. Blood in urine
  3. Kidney stones
- ### Urination
4. Burning
  5. Frequent
  6. Nighttime (2 or more)

7. Loss of control
8. Sexually transmitted disease
9. Herpes infection

### Men

10. Prostate infection
11. Difficulty urinating
12. Enlarged prostate
13. Erection problems

### Women

14. Painful intercourse
15. Abnormal discharge
16. Irregular periods

## H. Muscles, Bones, Joints

1. Arthritis
2. Joint pain(s)
3. Joint locking, clicking
4. Swollen joint(s)
5. Joint stiffness
6. Neck pain
7. Low back pain
8. Fracture or injury
9. Gout
10. Osteoporosis

## I. Skin/Breast

1. Lumps in breast
2. Breast disease
3. Rash (recent)
4. Hives
5. Eczema
6. Psoriasis
7. Mole, new or change
8. Hair loss

## J. Neurologic

1. Seizures / epilepsy
2. Headaches, frequent
3. Migraines (diagnosed by a doctor)

4. Numbness/tingling
5. Strength loss, specific body part
6. Stroke
7. Personality change
8. Tremor/shaking

## K. Psychiatric/Mental Health

1. Depression
2. Anxiety/nervousness
3. Insomnia, recent
4. Memory loss
5. Moodiness
6. Mental illness

## L. Endocrine

1. Diabetes
2. Thyroid disease
3. Hot flashes

## M. Blood/Lymphatic

1. Anemia
2. Cancer of any type
3. Swollen lymph nodes ("glands")
4. Bruising easily
5. Clots in legs

## N. Allergies/Immunologic

1. Allergies/hayfever
2. Chronic runny nose
3. Drainage into throat
4. Itchy eyes
5. Steroid use
6. HIV disease

## O. Other

1. Any other problems
2. I read these questions and I have no other medical problems