MEDICAL ASSOCIATES OF DREXEL HILL

Patient History

To provide you with the best possible care, please complete all sections below. This will give us a full medical and family history. All answers will remain CONFIDENTIAL.

Name: _____ Date: _____
Address: _____ Birthdate:_____
City/Zip: _____ Employer(s)_____
Phone: (H)_____(W)_____ Referred By: _____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Number of Children: _____ Occupation: Current: _____ Prior: _____
Reason for Visit Today: _____
With whom if anyone, may we discuss your care? _____
Relationship: _____

MEDICAL HISTORY

Do you have any allergies to the following (yes or no) if yes please describe type of reaction (rash, hives, difficulty breathing, etc.)

Latex _____ Foods_____ Medication _____ Other:_____
List item allergic to and describe reaction _____
_____
_____

Please list all medications you are currently taking with dose and directions: (attach list here)

_____
_____
_____
_____
_____
_____

Have you been diagnosed with or had problems with any of the following?

Arthritis or Gout_____ Blood Diseases, clotting problems_____
Bladder or Prostate_____ Breast Lump/Cyst_____
Breathing/Lungs_____ Cancer_____Type_____
Diabetes____ Years_____ Eyes/Vision_____
Hearing_____ Heart Disease _____
High Blood Pressure____Years___ Liver/Jaundice/Hepatitis_____
Kidney Diseases_____ Mental Illness_____
Seizures_____ Stomach or Bowel_____
Stroke_____ Thyroid_____
Tuberculosis_____ Venereal Diseases (VD)_____
Blood transfusions_____

SURGERY

Type: _____ Year: _____ Hospital: _____
_____ _____ _____
_____ _____ _____

SOCIAL HISTORY

Tobacco: Currently: _____ Stopped: _____ When? _____
Cigarettes: Packs/day _____ Number of years _____
Cigars: Number/day_____ Number of years_____
Pipe: _____
Caffeine: _____
Alcohol Type: _____ Amount: _____
Street Drugs:
Marijuana: _____ Cocaine, Crack: _____ Heroin: _____ Amphetamines, Speed: _____

FAMILY HISTORY

Family Member	Number	Living	Deceased	Age	Medical Problems
Mother					
Father					
Brothers					
Sisters					
Maternal Grandmother					
Grandfather					
Paternal Grandmother					
Grandfather					
Children					

REVIEW OF SYSTEMS

Do you now or have you ever had any of the following?
(CIRCLE ALL THAT APPLY)

Headache, blurred vision, fainting, seizures, etc.

Impaired vision, eye pain, diabetic eye disease, hearing loss, dizziness, trouble swallowing, etc.

Cough, shortness of breath, wheezing, etc.

Chest pain, rapid or irregular heart beat, swelling of the feet or legs, pain with walking (legs, chest), etc.

Nausea, vomiting, constipation, diarrhea, foods that upset you, weight loss, etc.

Pain with urination, blood in urine , difficulty starting, or stopping the urinary stream, foamy urine, urinary infections, stones, cysts, etc.

Arthritis, back pain, injuries, Rashes, skin ulcers, Anemia, bleeding disorders, etc.

For females:
Last menstrual period: _____
Number of pregnancies: _____ Number of living children: _____

Reviewed with Patient:

_____ _____ _____
Date **Patient Signature** **Physician Signature**