



Annual Medical History Form

Name _____ Medications/Vitamins/Supplements _____ Major Injuries/Surgeries _____ *MM/DD/YYYY*

Date _____

DOB _____

Biological Gender _____

Pronoun _____

Occupation _____

Preferred Pharmacy: _____

Allergies	Reaction	Allergies	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Optometrist: _____ Dentist: _____ Urologist: _____

Date Last Seen: _____ Date Last Seen: _____ Date Last Seen: _____

Smoking/Vaping

Current Past Never

Cigarettes/e-cigs a day _____

Age Started Smoking _____

Years smoked _____

Interest in quitting? _____

Caffeine: Yes No

Per Day _____

Type _____

Alcohol: Yes No

How many drinks per week? _____

Type: _____

Exercise: Yes No

Type _____

How often _____

Calcium Intake:

Milk _____

Cups/day _____

Supplements _____

Mg/day _____

Over the last two weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things? Not at all Several days More than half Nearly everyday
- Feeling down, depressed, or hopeless? Yes No
- How many times per year have you used a recreational drug or used a prescription medication for non-medical reasons? None 1 or more
- How many times in the past year have you had 5 or more drinks in a day? Not at all Several days More than half Nearly everyday

Screening History

Year of last Tetanus _____ Year of last TB test _____ Had a shingles shot? _____
 Do you get yearly flu shots? _____ Last pneumonia shot _____
 Have you had a colonoscopy? _____ If no, have you done a stool occult or cologuard? _____

Family Health Information

	Patient	Mother	Father	Siblings	Gparents	Aunts	Uncles
ADD/ADHD							
Anesthetic Reaction							
Asthma							
Autism							
Bleeding/Clotting Disorder							
Cancer <i>(Specify kind)</i>							
Depression/Anxiety							
Diabetes							
Early unexplained death							
Elevated Cholesterol							
Heart Attack <i>(age)</i>							
Heart Disease							
High Blood Pressure							
Mental Health – Other <i>(Bipolar, schizophrenia)</i>							
Migraines							
Scoliosis							
Seasonal Allergies							
Seizure Disorder							
Thyroid Disease							

Male Reproductive Health

Do you have prostate trouble? _____ Any penile discharge? _____
 Do you have trouble with Erectile Dysfunction? _____ Do you have trouble with dribbling or a slow stream? _____
 Do you have any lumps in/on your testicles? _____
 Have you had more than one partner in your lifetime? _____
 Have you had a new partner since your last exam? _____
 Do you have need for birth control now? _____ Current method of birth control? _____

Safety and Wellness

Yes No
 In the past year, have you been afraid of your partner/ex-partner?
 Do you feel physically and emotionally unsafe where you currently live?
 Has the lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
 In the past year, have you or any family member you live with been unable to get any of the following when it was really needed?
 Food Clothing Utilities Child Care Phone Medicine/Healthcare Other _____

Current Symptoms and/or Problems

Current	Past	None		Current	Past	None	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent UTIs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent vaginal warts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of STI
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning with Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of herpes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lose Urine when you don't want to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding after cut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB/TB exposure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual hair growth/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat/palpitations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worrisome moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Routine laxative use
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in bowel movement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black or tarry stools
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with eyes/seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with ears/hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoid troubles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in your muscles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness or Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problem chewing or swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or swelling in joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or weakness in arms/legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel Depressed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent lumps in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constant cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up phlegm or blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in Sleep
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel Nervous/Anxious