Name:____________________ Date: ______________ PERSONAL MD

Prescription Medications (use bak of page if needed)

Medication Name	Strength	How do you take it (each morning, twice a day,etc.)	Refill needed
			Y N
			Y N
			Y N
			Y N
			Y N

Preffered Pharmacy

Name Address/Crossroads City

Past Medical History (Mark all that apply)

	Insulin Resistance		Anxiety		Diverticulosis		Reflux
	Pre-Diabetes		Depression		Irritable Bowel Syndrome		Gout
	Diabetes		Mood Disorder		Gout		Kidney Disease
	High Blood Pressure		ADD/ADHD		Migraine Headaches		Kidney Stones
	High Cholesterol		Fibromyalgia		Prior Stroke		Seizures
	High Triglycerides		Thyroid Disease		Skin Issues		Substance Abuse
	Heart Disease		Hashimotos		Cancer: List Type(s)		

Drug and Food Allergies and Intolerances (list type of reaction)

Surgical History (include month and year if known)

Family History (If deceased include age relative died. Include any Cancer, Diabetes, High BP, High cholesterol, Alzheimer's)

Relationship	**Alive**	**Age**	**Medical History**
Mother	Y N		
Father	Y N		
Maternal Grandmother	Y N		
Maternal Grandfather	Y N		
Paternal Grandmother	Y N		
Paternal Grandfather	Y N		
Sibling	Y N		
Sibling	Y N		
Other	Y N		

Social History

Marital Status: Married Single Divorced Widowed

Current Smoker: No Yes How long have you smoked? How much do you smoke?

Alcohol Use: How many drinks per week do you average?

Caffeine Use: No Yes Coffee Tea Energy Drinks Chocolate Other

Occupation:

Immunization History (Include date last received)

Tetanus Pneumonia COVID

Shingles Flu

Name:____________________ **Medical History** PERSONAL MD

Preventive Care: Enter the date of the most recent test(s)		
Colon Cancer Screen	**Date**	**Result**
Test for blood in stool (Hemacult)		
Cologuard (DNA test)		
Colonoscopy		
Sigmoidoscopy		
For Men Only		
PSA Blood Test		
For Women Only		
Bone Density Exam		
Pap Smear		
Breast Exam by a Doctor		
Mammogram		
Pap Smear		
HPV Vaccine		

How many times have you been pregnant?	
How many children have you had?	
Genetic Test - have you been screened for either of the following?	
Lipoprotein a exam (genetic test for heart)	Yes No If Yes: Results
Apo E blood test (genetic test for Alzheimer's)	Yes No If Yes: Results

Other	
Do You have a living will?	Yes No
Do You have a Medical Power of Attorney?	Yes No
Do You have a Do Not Resuscitate (DNR)?	Yes No

Review of Symptoms (Mark all that apply)			
	Hearing Loss		Joint Pain
	Ringing In Ears		Back Pain
	Ear Pain		Problems with Balance
	Swallowing Issues		Joint Swelling
	Itchy Eyes		Skin Rash
	Visual Changes		Itchy Skin
	Eye Redness		Hair Loss
	Chest Tightness		Thinning Hair
	Wheezing		Dizziness
	Cough for over 4 weeks		Headaches (more than 4 / month)
	Leg Swelling		Tremor
	Skipped Heart Beats		Depressed Mood
	Abdominal Pain		Confusion
	Rectal Bleeding		Poor Concentration
	Rectal Pain		Lack of Interest
	Constipation		Sleep Problems
	Diarrhea		Snoring Problems
	Frequent Vomiting		Frequently Tired
	Bladder Leakage		Feeling Hopeless
	Lumpy Breast		Frequent Urination