

# MEDICAL HISTORY

This is a confidential part of your treatment and will be kept in this office. Information included on this form will not be released to anyone without written authorization from you.

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

BIRTHPLACE (city & state) \_\_\_\_\_ Years in NM: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy/phone #: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Oncologist: \_\_\_\_\_

Other Specialty Provider (s): \_\_\_\_\_

## AUTOIMMUNE DISEASES

- Hashimoto's Disease
- Lupus
- Sjogren's syndrome
- Other: \_\_\_\_\_

## CARDIO-VASCULAR HISTORY/DATE OF DIAGNOSIS

- Atrial fibrillation \_\_\_\_\_
- CAD (coronary artery disease) \_\_\_\_\_
- CHF (congestive heart failure) \_\_\_\_\_
- Defibrillator \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Hypercholesterolemia \_\_\_\_\_
- Myocardial infarction (heart attack) \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- PVD (Peripheral Vascular Disease) \_\_\_\_\_
- Stroke \_\_\_\_\_
- TIA (Transient Ischemic Attack) \_\_\_\_\_
- Other: \_\_\_\_\_

## ENDOCRINE

- Diabetes mellitus I II
- Hyperthyroidism (high)  Hypothyroidism (low)
- Other: \_\_\_\_\_

## GASTROENTEROLOGY

- Celiac disease  Crohn's disease/ulcerative colitis
- Diverticulitis  GERD (acid reflux)
- Gout  Hepatitis \_\_\_\_\_
- Irritable bowel syndrome
- Other: \_\_\_\_\_

## MUSCULOSKELETAL

- Osteoarthritis (Arthritis)
- Osteoporosis
- Psoriatic arthritis
- Rheumatoid arthritis
- Other: \_\_\_\_\_

## PULMONARY/TREATMENT

- Asthma
- COPD/Emphysema
- Hayfever/seasonal allergies
- History of tuberculosis
- Lung cancer
- Pulmonary embolism
- Sleep apnea CPAP Y N

## SKIN CANCER/Date of diagnosis and/or treatment

- Basal cell Carcinoma \_\_\_\_\_
- Melanoma \_\_\_\_\_
- Squamous Cell Carcinoma \_\_\_\_\_
- Other: \_\_\_\_\_

## SKIN CONDITIONS

- Acne
- Actinic Keratosis
- Alopecia
- Asteatosis cutis (excessive dry skin)
- Atypical mole
- Eczema (atopic dermatitis)
- History of measles
- History of Scarlet fever
- History of varicella zoster/chicken pox/shingles
- Psoriasis
- Syphilis
- Vitiligo
- Warts
- Other: \_\_\_\_\_

## URINARY/RENAL

- Benign prostatic hyperplasia
- Dialysis
- Kidney Disease
- Prostate cancer
- Other: \_\_\_\_\_

## MISCELLANEOUS

- AIDS/HIV
- Anemia
- Breast cancer
- DVT
- Leukemia
- Lymphoma
- Other: \_\_\_\_\_

## PSYCHOLOGICAL HISTORY

- ADD/ADHD
- Anxiety
- Depression

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Are you pregnant or breast feeding? \_\_\_\_\_ Do you plan on getting pregnant in the near future? \_\_\_\_\_

Have you had the pneumococcal (pneumonia) vaccination within the past five years? **Y** **N**

**Do you have a living will?** **Y** **N** **Do you have a DNR?** **Y** **N**

**Do you have an Advanced Care Plan/Medical POA? If yes, name/number:** \_\_\_\_\_

### PAST SURGICAL HISTORY

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Appendectomy (appendix)        | <input type="checkbox"/> Defibrillator                      | <input type="checkbox"/> Mastectomy <b>L</b> <b>R</b>     |
| <input type="checkbox"/> Cesarean (c-section)           | <input type="checkbox"/> Heart Valve Replacement            | <input type="checkbox"/> Nephrectomy (kidney removal)     |
| <input type="checkbox"/> Cholecystectomy (gallbladder)  | <input type="checkbox"/> Hip Replacement <b>L</b> <b>R</b>  | <input type="checkbox"/> Oophorectomy (ovary removal)     |
| <input type="checkbox"/> Colostomy (opening in stomach) | <input type="checkbox"/> Hysterectomy                       | <input type="checkbox"/> Pacemaker placement              |
| <input type="checkbox"/> Coronary bypass surgery        | <input type="checkbox"/> Knee Replacement <b>L</b> <b>R</b> | <input type="checkbox"/> Prostatectomy (prostate removal) |
| <input type="checkbox"/> Coronary stent placement       | <input type="checkbox"/> Lumpectomy <b>L</b> <b>R</b>       | <input type="checkbox"/> Transplant _____                 |
|   |   | <input type="checkbox"/> Other: _____                     |

**PLEASE LIST ALL CURRENT MEDICATIONS (including prescription, over-the-counter and herbal medications)**  
**Please list name, dosage and how the medication is administered.**

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**Do you require the use of coumadin (warfarin), aspirin, Plavix (clopidogrel), Pradaxa (dabigatran etexilate) or Xarelto (Rivaroxaban)?** If yes, please circle.

### DRUG ALLERGIES & REACTIONS

- NONE \_\_\_\_\_

### SOCIAL HISTORY

- Non-smoker  Former smoker  Current smoker how much? \_\_\_\_\_  Other \_\_\_\_\_

Do you drink alcohol? **Y** **N** If yes, how many drinks per day? \_\_\_\_\_ < 1 \_\_\_\_\_ 1 to 2 \_\_\_\_\_ 3 or more

How many times in the past year have you had 5 or more drinks in a day (men) or 4 or more drinks in a day (women)? \_\_\_\_\_

### FAMILY HISTORY (not the patient)

- Asthma if so, who? \_\_\_\_\_
- Basal Cell Carcinoma/Squamous Cell Carcinoma if so, who? \_\_\_\_\_
- Eczema if so, who? \_\_\_\_\_
- Hay fever if so, who? \_\_\_\_\_
- Melanoma if so, who? \_\_\_\_\_
- Psoriasis if so, who? \_\_\_\_\_