FAMILY FIRST SWIFTCARE

Medical Health History Form

Date ___________________________

Patient Name ____ Date of Birth _____________________

Reason for Visit ____

Check any medical problems that other doctors have diagnosed and any surgeries/hospitalizations:

☐ Asthma	☐ Ulcers	☐ Kidney Stones	☐ Tonsillectomy	☐ Artificial Joint
☐ Diabetes	☐ IBS	☐ Frequent UTI	☐ Thyroidectomy	☐ Back/spine pain
☐ Hypertension	☐ Crohns	☐ Stroke	☐ Gallbladder	☐ Artificial Heart Valve
☐ COPD/Emphysema	☐ Colitis	☐ Murmur	☐ Appendectomy	☐ Heart Bypass
☐ Acid Reflux/GERD	☐ Cancer	☐ Thyroid	☐ Hysterectomy	☐ Heart stints/Angioplasty

Additional information:

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Are you allergic to any medications? ☐ Yes ☐ No

If yes, which ones? ____

Current Medications (include doses and non-prescription drugs) ____

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Tobacco History: ☐ None If quit, when? ______________ Pack/cigarettes per day _______________________________________

Alcohol History: ☐ None Average drinks per day ___________ per month ______________ per year _____________________

Drugs: ☐ Marijuana ☐ Cocaine ☐ Opiates ☐ IV Use?

Family History

Do any of these problems run in your family? (please mark an "X" below that applies to your family history)

	Father	Mother	Sibling	Father's Father	Father's Mother	Mother's Father	Mother's Mother
Diabetes							
Heart Disease							
High Blood Pressure							
Stroke							
Cancer							
Gallbladder Disease							
Ulcer/Colitis/Crohn's							
Asthma/Respiratory							
Thyroid Disease							
Bleeding Disorders							
Tuberculosis							
Anemia							

Other Problems:
As you review the following list, please check any that apply to you.

- ☐ Decreased Hearing
- ☐ Ringing in ears
- ☐ Fainting
- ☐ Seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Headaches
- ☐ Migraine
- ☐ Double/blurred vision
- ☐ Eye Pain
- ☐ Depression
- ☐ Anxiety
- ☐ Agitation
- ☐ Memory Loss
- ☐ Moodiness
- ☐ Phobias
- ☐ Suicidal thoughts
- ☐ Sleeping problems
- ☐ Sinus trouble
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever/allergies
- ☐ Bronchitis/chronic cough
- ☐ Pneumonia/pleurisy
- ☐ Shortness of breath
- ☐ Arthritis
- ☐ Back pain
- ☐ Numbness/tingling
- ☐ Foot pain
- ☐ Gout
- ☐ Bone fracture/joint injury
- ☐ Osteoporosis
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hair Loss
- ☐ Mole, changing

- ☐ Chest Pain
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Swollen ankles
- ☐ Leg pain when walking
- ☐ Cold/numb feet
- ☐ Varicose veins/phlebitis
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Weight loss/gain
- ☐ Persistent vomiting/nausea
- ☐ Hernia
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Jaundice/Hepatitis
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Hemorrhoid
- ☐ Bladder leakage
- ☐ Incontinence
- ☐ Pain/burning during urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ STDs

Males

- ☐ Testicular pain
- ☐ Penile pain/discharge

Females

- ☐ Irregular menstrual cycles
- ☐ Pain/bleeding during/after sex
- ☐ Flushing/menopause

Date of last PAP _______________

- ☐ Normal
- ☐ Abnormal

If any of the above boxes were checked, please explain:

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Patient/Guardian Signature ____ Date ____________________________________