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PHYSICIAN NETWORK

Medical History Form

Personal Information:

Name:_____ Date:_____ SSN(Last 4):_____

Email:_____ DOB:_____

Address:_____ Occupation:_____

City:_____ State:_____ Zip:_____ Cell:_____

Gender:_____ Height:_____ Weight:_____

Current Medications (please be specific and provide names and dosage):

_____

_____

_____

Current Vitamins & Supplements:

_____

_____

Lifestyle Habits (check all that apply):

☐ Smoke: Packs Daily? _____ How long?_____

☐ Alcohol: Drinks/Week?_____

☐ Coffee: Cups Daily?_____

☐ Exercise: Days/Week _____

☐ Difficulty falling asleep?_____

☐ Difficulty staying asleep?_____

☐ Sleep apnea?_____ Treatment? _____

☐ Daytime drowsiness? _____

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Medical History (check all that apply & provide a brief explanation)

- ☐ Pacemaker: _____
- ☐ Shortness of Breath: _____
- ☐ Heart Palpatations: _____
- ☐ Heart murmur: _____
- ☐ Chest pain: _____
- ☐ Dizziness/Fainting: _____
- ☐ Peripheral Vascular Disease: _____
- ☐ Allergies/Hay Fever: _____
- ☐ Asthma: _____
- ☐ Bronchitis: _____
- ☐ Pneumonia: _____
- ☐ Lactose Intolerant: _____
- ☐ Gallbladder Disease: _____
- ☐ Prostate Disease: _____
- ☐ Bowel Irregularities: _____
- ☐ Incontinence: _____
- ☐ Venereal Disease: _____
- ☐ Frequent Infections: _____
- ☐ Hepatitis: _____

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Medical History (continued)

- [ ] Anemia: _____
- [ ] Arthritis: _____
- [ ] Gout: _____
- [ ] Headachesr: _____
- [ ] Chronic Rashes: _____
- [ ] Rheumatic Fever: _____
- [ ] Mumps: _____
- [ ] Measlesr: _____
- [ ] Rebella: _____
- [ ] Polio: _____
- [ ] Diphtheria: _____
- [ ] Tetanus: _____
- [ ] Diabetes: _____
- [ ] Cancer: _____
- [ ] Other: _____

_____

_____

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Symptoms & Conditions	(Please Circle or Write in Comments Section) None to Severe					Comments
Decreased sense of well being	1	2	3	4	5	_____
Increasingly stressed	1	2	3	4	5	_____
Decreasing muscle strength	1	2	3	4	5	_____
Muscle loss	1	2	3	4	5	_____
Thinning or loss of hair	1	2	3	4	5	_____
Headaches/migraines	1	2	3	4	5	_____
Unexplained weight loss	1	2	3	4	5	_____
Abdominal bloating	1	2	3	4	5	_____
Anxiety or irritability	1	2	3	4	5	_____
Dry skin	1	2	3	4	5	_____
Sleep issues	1	2	3	4	5	_____
Water Retention	1	2	3	4	5	_____
Weight gain/increase in fat	1	2	3	4	5	_____
Breast tenderness	1	2	3	4	5	_____
Decreased focus/concentration	1	2	3	4	5	_____
Depression	1	2	3	4	5	_____
Fatigue/energy loss	1	2	3	4	5	_____
Libido issues/loss of interst in sex	1	2	3	4	5	_____
Mood swings	1	2	3	4	5	_____

(Females Only)

Menstrual Abnormalities	1	2	3	4	5	_____
Painful Intercourse	1	2	3	4	5	_____
Hot flashes	1	2	3	4	5	_____
Night sweats	1	2	3	4	5	_____
Vaginal Dryness	1	2	3	4	5	_____

OBGYN Name: _____ Date of Last Period: _____

Pregnant: ☐ Yes ☐ No

Date of Last PAP: _____ ☐ Abnormal ☐ Normal

Date of Last Mammogran: _____ ☐ Abnormal ☐ Normal