

Eagle Creek Family Medicine  
Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Former Names or Alias: \_\_\_\_\_ Nickname: \_\_\_\_\_

**Please list any medications, including Over the Counter medications/supplements you are taking.**

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Times per day \_\_\_\_\_

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Do you have any allergies to medications or medical supplies? Yes/No  
If so, what are they: \_\_\_\_\_

Have you ever been treated for any of the following:

- High Blood Pressure Yes/No
- High Cholesterol Yes/No
- Diabetes or blood sugar problems Yes/No
- Thyroid problems Yes/No
- Blood disorders (ie Anemia or Blood clots) Yes/No
- Psychiatric problems (ie Depression/Anxiety) Yes/No
- Stomach conditions (ie Ulcers/Reflux) Yes/No
- Neurologic disorders (ie Headaches/Seizures) Yes/No
- Urinary conditions (ie Incontinence/Kidney Stones) Yes/No
- Pulmonary conditions (ie Asthma) Yes/No
- Cancers Yes/No
- Heart Problems (ie Coronary Artery Disease/Murmurs) Yes/No
- Stroke Yes/No

If yes to any of the above, please list below:

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**Please list any surgeries you have had. Include dates and locations** \_\_\_\_\_

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**Have you ever been hospitalized for any illnesses, other than surgeries? Please list dates and locations**

**Family Medical History: Please list any medical/health conditions for each family member.**

Father:                      alive/deceased      \_\_\_\_\_

Mother:                     alive/deceased      \_\_\_\_\_

Paternal Grandfather:    alive/deceased      \_\_\_\_\_

Paternal Grandmother:    alive/deceased      \_\_\_\_\_

Maternal Grandfather:    alive/deceased      \_\_\_\_\_

Maternal Grandmother:    alive/deceased      \_\_\_\_\_

Siblings:                    # of Brothers: \_\_\_\_\_ # of Sisters: \_\_\_\_\_

Please list any medical/health conditions for your siblings

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**Social History:**

- Single
- Married
- Divorced/Separated
- Widowed

Do you smoke? Yes/No Have you ever smoked? Yes/No, if yes when did you quit? \_\_\_\_\_

Do you drink alcohol? Yes/No If yes, how often and how much? \_\_\_\_\_

Any history of drug use? Yes/No If yes, what drug(s)? \_\_\_\_\_

Caffeine Intake? \_\_\_\_\_

Do you have any children? Yes/No If yes, how many? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Religious Preference? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

**OB/GYN History: Females Only ☺**

Have you ever had an abnormal pap smear? Yes/No

If yes, did you receive treatment? Yes/No

If treated, please list with date and type of treatment (ie cryo, colposcopy, LEEP) \_\_\_\_\_

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Do you have any known history of HPV (Human Papilloma Virus)? Yes/No

Last Pap Smear \_\_\_\_\_

Last Mammogram \_\_\_\_\_

Last Bone Density study \_\_\_\_\_

Age of first period \_\_\_\_\_

Age at Menopause \_\_\_\_\_

**Menstrual History: Females only ☺**

Number of days between periods (1<sup>st</sup> day to 1<sup>st</sup> day of next period) \_\_\_\_\_

Number of days bleeding \_\_\_\_\_

Light/Moderate/Heavy flow \_\_\_\_\_

Do you have any bleeding in between periods? Yes/No

Age of first intercourse? \_\_\_\_\_ How many partners in your lifetime? \_\_\_\_\_

Do you have any vaginal bleeding after intercourse? Yes/No

Do you have any pain: with intercourse? Yes/No With you menstrual cycles? Yes/No

What form of birth control, if any, are you using? Please circle

- |                    |                |
|--------------------|----------------|
| None               | Rhythm         |
| Oral Contraception | Condoms        |
| Depo-Provera       | Diaphragm      |
| IUD                | NuvaRing       |
| Spermicides        | Tubal Ligation |
| Vasectomy          | Withdrawl      |

Have you ever been told you have the following: Endometriosis Ovarian Cysts Fibroids PMS

Have you ever had an STD? Please circle

- Gonorrhea Chlamydia Syphilis Genital Warts HPV Herpes

Have you ever had an abnormal mammogram? Yes/No

Any breast problems? Yes/No

Are you on Hormone Replacement Therapy? Yes/No

**Pregnancy History: Females Only ☺**

Total number of pregnancies \_\_\_\_\_ Ectopic \_\_\_\_\_ Miscariages \_\_\_\_\_ Abortions \_\_\_\_\_

# of Vaginal Deliveries \_\_\_\_\_ # of C-Sections \_\_\_\_\_

Any complications with any of the above? Yes/No

If yes, please explain: \_\_\_\_\_

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