Central Ozarks Medical Center

Patient Medical History

Date: ____/____/______

Name: ________________________________ DOB: ____/_____/_______ Sex: M / F

Past Medical History:

□ Diabetes	□ Heart Murmur	□ Stroke
□ High Blood Pressure	□ Rheumatic Fever	□ Epilepsy (seizures)
□ High Cholesterol	□ Anxiety	□ Cataracts
□ Thyroid Dysfunction	□ Depression	□ Kidney Disease
□ Goiter	□ Bipolar/Schizophrenia	□ Kidney Stones
□ Cancer (type)____________	□ Pneumonia	□ Crohn's Disease
□ Leukemia	□ Pulmonary Embolism	□ Colitis
□ Psoriasis	□ Asthma	□ Anemia
□ Angina	□ Hay Fever/Allergies	□ Jaundice
□ Heart Problems	□ Emphysema/ COPD	□ Hepatitis
□ Stomach or Peptic Ulcer	□ GERD	□ Tuberculosis
□ HIV/AIDS	□ Other: _________________	□ Other: _________________

Current Medication:

Medication	Dose	Frequency

Medication Allergies (medication and reaction)**:**

____

____

Family Medical History:

Please check the box that applies to your family members (Additional space provided below for health problems that aren't listed).

Family Members	**Diabetes**	**Hypertension**	**Heart Disease**	**Stroke**	**Mental Illness**	**Cancer**
Daughter(s)						
Father						
Son(s)						
Mother						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Brother(s)						
Sister(s)						

Family Member	Present Age	Age at Death	Health Problems including Cause of Death
Daughter(s)			
Father			
Son(s)			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Sibling(s)			

Social History:

Marital Status: Single__ Married__ Divorced__ Widowed__

Do you have children? □Yes □No If so, how many?

What is your highest educational level? □High School □Some college courses

□ College graduate □Advanced degree

What is your current or past occupation? ____

Are you currently working? □Yes □No If yes, how many hours per week? _______________

If not are you □Retired □Disabled □Sick Leave Do you receive disability or SSI? □Yes □No

If yes, for what disability? ________________ What date did this disability begin? __________

How much exercise do you get each week? ______________________________

What kind of exercise? ____

Do you smoke/chew tobacco? □ Yes □No If yes, how much and long? _____________________

If no, have you in the past? ____________________

Do you drink alcohol? □Yes □No If yes, how much? ____________________________

Have/Do you use any other drugs? □Yes □No If so, what drug? _______________________

How many people live in the household?

Surgical History:

Month/Year	Operation

Recent Hospitalizations:

Month/Year	Reason for Admission

List All Physicians:

Name	Specialty

If you are female, please complete the following portion:

Obstetric History:

Have you ever been pregnant? □Yes □No Number of Pregnancies? _______________

Date of Pregnancy *Date of birth/ miscarriage/ termination*	Male/Female	*Please list one* Vaginal Delivery/C-Section /Miscarriage/termination	Weight of Baby