

North Country Medical Associates

Medical and Family History Form

Please fill in the circles for the appropriate health information

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

Your Allergies

- NONE Codeine Iodine Morphine Penicillin Sulfa Versed
 Aspirin Demerol Latex Novocaine Propofol Tape Other _____

Past Medical Illnesses

- NONE Hepatitis B Clotting Disorder High Cholesterol Parkinson's Disease
 Anemia Hepatitis C Congestive Heart Failure High Triglycerides Phlebitis
 Cirrhosis of Liver Hiatal Hernia COPD History of Suicide Attempt Pneumonia
 Colitis Irritable Bowel Syndrome Dementia HIV/AIDS Rheumatic Fever
 Colon Cancer Lactose Intolerance Depression Hyperthyroidism Rheumatoid Arthritis
 Colon Polyps Reflux Emphysema Hypothyroidism Seizures
 Crohn's Disease Stomach Ulcer Endocarditis Irregular Heart Beat Skin Cancer
 Diabetes Ulcerative Colitis Frequent Urinary Tract Infections Kidney Disease Sleep Apnea
 Diarrhea Alzheimer's Disease Glaucoma Kidney Failure Stroke
 Diverticulitis Asthma Gout Kidney Stone TB (Tuberculosis)
 Diverticulosis Atrial Fibrillation Heart Attack Lupus TB Skin Test Positive
 Duodenal Ulcer Back Pain Heart Disease Migraines Thyroid Disease
 Fatty Liver Breast Cancer Heart Failure Osteoarthritis Uterine Cancer
 Gallstones Cancer Heart Murmur Pancreatitis
 Hepatitis A Chronic Lung Disease High Blood Pressure Paralysis Other _____

Previous Endoscopic Procedures/Surgeries

- NONE Artificial Heart Valve Gallbladder Hysterectomy Total Thyroid
 Colonoscopy Breast Heart Bypass Surgery Joint Surgery/Replacement Tonsils
 EGD/Upper Endoscopy C-Section Heart Stent Kidney Transplant Surgery
 ERCP Cardiac Surgery Heart Valve Replacement Obesity Surgery Tubal Ligation
 Liver Biopsy Left Colon Resection Hemorrhoids Pacemaker Vasectomy
 Sigmoidoscopy Right Colon Resection Hiatal Hernia Prostate
 Appendix Defibrillator Hysterectomy Stomach Other

Social History

Marital Status:

- Single Married Separated
- Divorced Widowed

Social History Recreational Drugs:

- I have never used recreational drugs
- I have been treated for substance abuse
- I currently use recreational drugs
- I have used recreational drugs in the past

Social History Alcohol:

- Never
- Rarely
- Daily
- Prior abuse
- More than 2 days/week
- Less than 2 days/week
- I quit using alcohol

Number of Children:

- 1 2 3 4 5 6+ None

Social History Tobacco:

- I have use tobacco products
- I quit using tobacco products
- I have never used tobacco products
- Cigarettes/Cigar

Social History Occupation:

- Patient
- Occupation _____ Veteran Retired

REVIEW OF SYSTEMS (Current Symptoms)

Gastrointestinal:

- NONE
- constipation
- indigestion/heartburn
- persistent abdominal pain
- black tarry stools
- difficulty swallowing
- lack of appetite
- persistent diarrhea
- bloating/gas
- frequently use of laxatives
- mucus in stool
- weight loss
- blood in stools
- hemorrhoids
- persistent nausea/vomiting
- Other _____

Urinary:

- NONE
- Kidney disease/failure
- Frequent urinary infections
- Change in urinary frequency

- Other _____

Skin:

- NONE
- dryness
- hives
- itching
- jaundice
- rashes
- suspicious lesions
- Other _____

Cardiovascular:

- NONE
- chest pain with exertion
- palpitations
- ankle swelling
- irregular heart beat
- shortness of breath
- Other _____

Neurological:

- NONE
- anxiety
- localized weakness
- loss of sensation
- memory loss
- migraines
- tremors
- Other _____

Endocrine:

- NONE
- cold intolerance
- excessive thirst
- heat intolerance
- Other _____

Constitutional:

- NONE
- chills
- fatigue
- fever
- loss of appetite
- night sweats
- Other _____

Psychiatric:

- NONE
- anxiety/panic
- depression
- inability to concentrate
- suicidal thoughts
- Other _____

Eyes:

- NONE
- blurred vision
- light sensitivity
- pain
- wearing of glasses/contacts
- Other _____

Hematologic:

- NONE
- abnormal bleeding
- bruise/bleed easily
- Other _____

Ears, Nose & Throat:

- NONE
- hearing loss
- hoarseness
- nose bleeds
- sore throat
- Other _____

Musculoskeletal:

- NONE
- back pain
- joint pain
- muscle pain
- stiffness
- Other _____

Respiratory:

- NONE
- cough
- shortness of breath
- Other _____

Immunologic:

- NONE
- allergies (environmental)
- persistent infections
- recurrent hives
- strong allergic reactions
- Other _____

FAMILY HISTORY

	Father	Mother	Child(ren)	Brother(s)	Sister(s)	Grandparents
Colitis	O	O	O	O	O	O
Colon Cancer	O	O	O	O	O	O
Age at diagnosis	_____	_____	_____	_____	_____	_____
Colon Polyps	O	O	O	O	O	O
Crohn's Disease	O	O	O	O	O	O
Diabetes	O	O	O	O	O	O
Esophageal Cancer	O	O	O	O	O	O
Gall Bladder Disease	O	O	O	O	O	O
Heart Trouble	O	O	O	O	O	O
Liver Cancer	O	O	O	O	O	O
Liver Disease	O	O	O	O	O	O
Pancreas Cancer	O	O	O	O	O	O
Stomach Cancer	O	O	O	O	O	O
Ulcer Disease	O	O	O	O	O	O
Ulcerative Colitis	O	O	O	O	O	O
Other Cancer	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

