PARIS LAKES HEALTH GROUP

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PATIENT MEDICAL HISTORY INTAKE FORM

Today's Date:_____/_____/_____ Patient SS#:_____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ST: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Best way to contact? Home Cell

Email: _____

How did you hear about us? ☐ Facebook ☐ Internet ☐ Family/Friend ☐ Insurance Co.
☐ Other _____

SOCIAL HISTORY (Please check or answer anything that applies)

☐Consume Alcohol - Never	☐Use Tobacco - Never	☐Drug use - Never
☐Consume Alcohol - Occasionally	☐Use Tobacco - Yes Previously Year Stopped _____	☐Drug use - Yes Previously If Yes, How much?_____
☐Consume Alcohol - Moderately	☐Cigarettes #Packs Per day: ____	☐Marijuana ☐Heroin
☐Consume Alcohol - Heavy	☐Cigars	☐Cocaine ☐Other:_____
# of Children:_____	☐Pipe	
# of Child Births: _____	☐Chew Tobacco	☐Marital Status – Divorced
# of Miscarriages: _____	☐STD – Never	☐Marital Status – Married
☐Education - College	☐STD – Positive (history of)	☐Marital Status – Significant Other
☐Education – Grade School	☐Employer_____ ☐Retired	☐Marital Status - Single
☐Education – Graduate School		☐Marital Status - Widowed
☐Education – High School		

FAMILY HISTORY (Please check any that apply)

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Neurologic Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐

PAST MEDICAL HISTORY (Please check any that apply)

☐Alcohol Abuse	☐Dizziness/Vertigo	☐Herpes	☐Leukemia
☐Anemia/Panic	☐Depression	☐History of DVT/PE	☐Liver Disease
☐Anxiety	☐Easy Bleeding	☐HIV Infection	☐Migraine Headache
☐Asthma	☐Eczema	☐Heart Disease	☐Osteoporosis
☐Atrial Fib (A-Fib)	☐Emphysema	☐High Blood Pressure	☐Pneumonia; Previous
☐Attention Deficit Disorder	☐Esophageal Reflux	☐Hodgkin's Disease	☐Previous Stroke
☐Bronchitis	☐Fatigue	☐Insomnia	☐Rheumatoid Arthritis
☐Back Problems	☐Gastrointestinal Disorder	☐Kidney Disease	☐Seizure Disorder
☐Cancer Type:_____	☐Glaucoma	☐Kidney Stones	☐Sleep Apnea, CPAP
☐Concussion	☐Headache	☐Lupus	☐Thyroid Disorder
☐Diabetes Mellitus	☐Hepatitis C.	☐Lyme Disease	

SURGICAL HISTORY (Please check any that apply and indicate year of surgery)

Surgery	**Date**	**Surgery**	**Date**	**Surgery**	**Date**
☐Appendectomy		☐Ear Tubes		☐Prostate Surgery	
☐Back Surgery		☐Hernia Repair		☐Shoulder Surgery	
☐Breast Surgery		☐Hysterectomy; Partial		☐Sinus Surgery	
☐Cataract Surgery		☐Hysterectomy; Total		☐Tonsillectomy	
☐C-Section		☐Hip Surgery		☐Thyroid Surgery	
☐Cholecystectomy (Gallbladder removal)		☐Knee Surgery		☐Vasectomy	
☐Colonoscopy		☐Laparoscopy Where? _____		☐Wisdom Teeth	
☐Cosmetic Surgery		☐Pacemaker Placement		☐Other:	

DRUG ALLERGIES (Please list your drug allergies)

Please list your drug allergies…		
Allergy	Reaction	Year

CURRENT MEDICATIONS (Please complete table below for your current medications)

Medication Name	**Dosage**	**Frequency**
Example) Lisinopril	10mg	1 tablet once a day

CURRENT MEDICATIONS Continued...

REVIEW OF SYSTEMS (Please check box if you are experiencing the symptom)

System	Symptoms		
Cardiovascular	☐Chest pain ☐Swelling in feet & ankles	☐Lightheaded/dizzy	☐Palpitations
Constitution	☐Fatigue ☐Unexplained weight gain	☐Fever & chills ☐Weakness	☐Unexplained weight loss
Ear-Nose-Throat-Mouth	☐Dry mouth ☐Runny Nose	☐Hearing loss ☐Sore throat	☐Ringing in ears
Endrocrine	☐Fatigue	☐Weight Gain	☐Weight Loss
Eyes	☐Blurry	☐Pain	
Gastrointestinal	☐Nausea ☐Vomiting	☐Diarrhea ☐Constipation	☐Abdominal Pain
Genitourinary	☐Painful Urination	☐Frequent Urination	☐Vaginal Discharge
Hematologic/Lymph	☐Easy Bleeding	☐Swollen Lymph Nodes	
Integumentary	☐Rash	☐Bothersome Skin Lesions	
Musculoskeletal	☐Joint Pain	☐Swelling	☐Muscle Pain
Neurological	☐Numbness	☐Muscle Weakness	☐Memory Loss
Psychological	☐Anxiety	☐Depression	
Respiratory	☐SOB	☐Cough	