BRANDYWINE FAMILY OF EXTON
MEDICAL/SURGICAL HISTORY FORM

Patient Name: _____ **Birth Date:** _____
Reason for Today's Visit: _____
Primary Care Physician: _____

PAST MEDICAL HISTORY (Circle all that apply)

Heart Disease	Heart Attack	High Blood Pressure	High Cholesterol
Kidney Disease	Liver Disease	Hepatitis	Acid Reflux
Asthma	Emphysema	Arthritis	Stroke
Cancer	Thyroid Disease	Diabetes	Seizures
Depression	Blood Clots	Chronic Pain	HIV/AIDS
Blood Clots	Excessive Bleeding		

Other Conditions not listed: _____
_____

PAST SURGICAL HISTORY

Procedure — Date of Procedure

_____
_____
_____
_____

FAMILY HISTORY (Circle all that apply)

Heart Disease	Heart Attack	High Blood Pressure	High Cholesterol
Kidney Disease	Liver Disease	Stroke	Cancer
Seizures	Emphysema	Diabetes	Thyroid Disease
Depression	Excessive bleeding	Inflammatory Bowel Disease	Blood clots

Other Significant Medical Conditions: _____

Father _____ Living _____ Deceased (Age at death & cause) _____

Mother _____ Living _____ Deceased (Age at death & cause) _____

CURRENT MEDICATIONS & DOSAGE (Include all herbal & over the counter meds)

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES (Medications, Food, Etc.) — Type of Reaction (State "none" if none)

_____ _____
_____ _____

DO YOU HAVE A LIVING WILL ____ YES ____ NO
(Please provide a copy to the office)

MEDICAL/SURGICAL HISTORY FORM

Have you experienced any of these symptoms within the past 6 months?
(State "none" if not applicable)

1) Constitutional (Change in weight, Fever, Chills, Poor appetite)_____
2) Eyes (Change in vision, Blurred vision) _____
3) Ears/Nose/Throat/Allergy _____
4) Heart (Chest pain, Heart pounding, Swelling of legs)_____
5) Lungs (Shortness of breath, Difficulty breathing, Cough) _____
6) Gastrointestinal (Abdominal pain, nausea or vomiting, Indigestion, Heartburn, Blood in stool, Black bowel movements, Diarrhea, Constipation, Trouble Swallowing, Belching or Gas, Swollen abdomen)_____
_____
7) Kidneys/Bladder (Cloudy or Bloody urine, Burning or pain when urinating, Sexual dysfunction, Erectile dysfunction, Do you get up at night to urinate?)
_____
8) Joints/Muscles (Pain, Stiffness, Muscle weakness, Back pain, Stiff neck)
_____
9) Brain/Spinal Cord (Seizures, Headaches, Lightheadedness, or Dizziness
_____
10) Blood Disorder (Easy Bruising or Bleeding, Excessive Clotting, Phlebitis or VaricoseVeins
_____
11) Cardiovascular (Cold feet or legs) _____
12) Skin (Rashes, Moles) _____
13) Psychiatric (Depressed mood, Anxiety, History of abuse/domestic violence, Difficulty sleeping, getting asleep or staying asleep)
_____
14) Breast (Lump, Pain, Discharge) _____

Have you ever had?

An abnormal chest x-ray? Yes _____ No _____ How long ago?_____

An abnormal electrocardiogram? Yes _____ No_____ How long ago?_____

*****Women Only******

Age Menstrual Period began _____ Last Menstrual Period _____

Age at Menopause _____ Hysterectomy: Yes No Ovaries Removed Yes No

Number of Children _____ Age at First Delivery _____

Number of Pregnancies_____ Number of Miscarriages or Abortions_____

Do you use Birth Control Pills? Yes No

MEDICAL/SURGICAL HISTORY FORM

Do you smoke? Yes No If yes, how much? _____

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

Do you use street drugs? (Heroin, Cocaine, Speed, Marijuana, etc,) Yes No

Do you exercise regularly? Yes No If yes, how much? _____

Do you drink coffee, tea or coke? Yes No If yes, how much? _____