McKinney Comprehensive Care
Medical History **Date:_____**

Name _____ Age _____ Date of Birth _____
Address _____ Sex: ☐ M ☐ F
_____ Home Phone _____
_____ Work Phone_____ Cell _____
Occupation _____ Emergency Contact _____
Phone_____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Married, spouse's name _____
Children's names and ages_____

Allergies to Foods, Medications, X-ray Dyes, or Other Substances ☐ No ☐Yes
(If yes, please list name and type of reaction):

_____ _____ _____
_____ _____ _____

Medications (Prescription, Over-the-counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Past Medical History and Review of Systems
Please circle if ***you*** have had problems with or are presently experiencing any of the following:

1. High Blood Pressure	13. Bronchitis	26. Change in Bowel Habits	38. Arthritis
2. Diabetes	14. Pneumonia	27. Unexplained Weight	39. Low Back Problems
3. Cancer	15. Persistent Cough	gain / loss	40. Skin Disease
4. Heart Disease	16. T.B.	28. Hemorrhoids	41. Blood Disorder
5. Chest Pain or	17. Hay Fever	29. Gall Bladder Disease	42. Venereal Disease (STD)
Tightness	18. Abdominal Pain	30. Colitis	43. Anxiety
6. Shortness of Breath	19. Indigestion	31. Hepatitis or Jaundice	44. Depression
7. Swollen Ankles	20. Nausea	32. Thyroid Disease	45. Anemia
8. Palpitations	21. Vomiting	33. Head or Neck Radiation	46. Alcohol Abuse
9. Lightheadedness	22. Constipation	34. Headaches	47. Drug Abuse
10. Frequent Urination	23. Diarrhea	35. Kidney Disease	48. Gout
11. Rheumatic Fever	24. Blood in Stool	36. Kidney Stones	49. Other_____
12. Asthma	25. Ulcers	37. Difficulty Urinating	

Notes:_____
_____

Surgical History (please list any surgeries you have had and approximate dates)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Female / Gynecologic and Obstetric History

Age at onset of Periods:_____ Frequency of Periods:_____ Duration:_____
Pregnancies _____ Births _____ Miscarriages_____
Prolonged or Abnormal Bleeding? ☐ No ☐ Yes (please describe)_____
Leakage of Urine or Incontinence? ☐ No ☐ Yes (please describe)_____
Pelvic Pain? ☐ No ☐ Yes (please describe)_____
Pain with Intercourse? ☐ No ☐ Yes (please describe)_____
Abnormal Vaginal Discharge? ☐ No ☐ Yes (please describe)_____
Do you use Birth Control? ☐ No ☐ Yes (Method)_____
When was your last:
Pap Smear_____ Breast Exam_____ Mammogram_____

Patient Name: **Date:**

Male History

Leakage of Urine or Incontinence? ☐ No ☐ Yes (please describe)_____
Pain with Intercourse? ☐ No ☐ Yes (please describe)_____
Penile Discharge? ☐ No ☐ Yes (please describe)_____
Erectile problems/ Impotence? ☐ No ☐ Yes (please describe)_____
Do you use condoms? ☐ No ☐ Yes
When was your last:
Prostate exam_____ PSA Blood test_____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family member(s)?	Age when diagnosed?
Cancer (please list type)	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Illness (anxiety / depression, etc)	_____	_____
Drug or Alcohol Addiction	_____	_____
Glaucoma	_____	_____
Bleeding or Clotting problems	_____	_____
Other_____	_____	_____

Prevention

Immunization History (have you had?):

Tetanus Vaccine ☐ No ☐ Yes When? _____ Flu Vaccine ☐ No ☐ Yes When? _____
Pneumonia Vaccine ☐ No ☐ Yes When? _____ Hepatitis B Vaccine ☐ No ☐ Yes When? _____

Habits

Do you smoke? ☐ No ☐Yes (How many packs per day)_____
Do you use recreational drugs? ☐ No ☐ Yes (list type)_____
Do you drink alcohol? ☐ No ☐ Yes (Number of drinks per week?) _____
Do you drink Caffeinated beverages? ☐ No ☐Yes (number of cups per day?) _____
Do you exercise regularly? ☐ No ☐ Yes
Do you wear a seat belt / safety helmet? ☐ No ☐ Yes

Home environment:

Do you own a gun? ☐ No ☐Yes (Is it kept out of the reach of child and kept unloaded/) ☐ No ☐ Yes
Do you have smoke detectors? ☐ No ☐ Yes
Have you ever been physically hurt by your partner? ☐No ☐ Yes (please explain)_____
Have you ever been afraid of your partner? ☐ No ☐ Yes (please explain)_____

Disease Risk assessment:

Have you ever worked with hazardous materials (asbestos, chemicals, lead, etc.)? ☐ No ☐Yes (please list)_____
Have you ever engaged in any activity that would put you at risk of HIV/AIDS? (IV drug use, same sex partner, prostitution) ☐ No ☐ Yes
Do you wish to be tested for HIV/AIDS? ☐ No ☐Yes

Miscellaneous:

Do you have a Donor Card? ☐ No ☐ Yes
Do you have a Living Will/Adv. Directive? ☐ No ☐ Yes

Reviewed by Physician:_____Date:_____