9 East High St. (Rear) . Carlisle, PA 17013 . (717) 440-0498 . FAX (717) 918-5784

MEDICAL HISTORY

Name______________________________ DOB________________

Your Past Medical History and Chronic Medical Conditions (check all that apply)

High Blood Pressure		High Cholesterol/Triglycerides		Diabetes Type 1	
Diabetes Type 2		Low Thyroid (hypothyroid)		Overactive Thyroid (hyperthyroid)	
Anxiety		Depression		Bi-Polar Disorder	
ADHD/ADD		Schizophrenia		Migraine Headaches	
Tension Headaches		Low Back Pain		Upper Back Pain	
Neck Pain		Hearing Loss/Hard of Hearing		Glaucoma	
Cataracts		Wears Glasses		Wears Dentures	
Eczema		Psoriasis		Breast Cancer	
Colon Cancer		Lung Cancer		Thyroid Cancer	
Skin Cancer		Brain Tumor		Bladder Cancer	
Brain Aneurysm		Abdominal Aneurysm		Arthritis	
Epilepsy		GERD/Heartburn/Reflux		Atrial Fibrillation (A-fib)	
Heart Attack		Congestive Heart Failure (CHF)		Alzheimer's/Dementia	
Ankle Swelling (Edema)		Varicose Veins		Stroke (CVA)	
Diarrhea		Constipation		Prostate Disease	
Low Blood Pressure		Urine Leakage (Incontinence)		Hemorrhoids	
Liver Disease		Kidney Disease		Erectile Dysfunction	
PMS		Heavy Periods		PCOS	
Seasonal Allergies		TMJ (jaw problems)		HIV/AIDS	
Overweight/Obesity		Fibrocystic Breast Disease		Chronic Fatigue Syndrome	
Fibromyalgia		Other:		Other:	
Other:		Other:		Other:	

Past Surgical History (please indicate year if known)

Tonsillectomy		Adenoidectomy		Gall Bladder Removal	
Thyroid Removed		Heart Bypass		Heart Valve Replacement	
Bowel Surgery		Hysterectomy		Tubal Ligation	
Vasectomy		Wisdom Teeth Removal		Hip Replacement R L	

Cataract Removal		Knee Replacement R L		Spleen Removed	
Face Lift		Tummy Tuck		Eye Lift	
Ear Tubes (Myringotomy)		Carotid Endarterectomy		Hammer Toes	
Foot Surgery		Elbow Surgery		Hand Surgery	
Colonoscopy		EGD Endoscopy		Heart Catheterization	
Knee Laparoscopy		Abdominal Laparoscopy		Bronchoscopy	
Other:		Other:		Other:	
Other:		Other:		Other:	

Reviewed by ____ Date____________________

Name____DOB____________________

Family History (please indicate the diseases your relatives have (check all that apply)

High Blood Pressure		High Cholesterol/Triglycerides		Diabetes Type 1	
Diabetes Type 2		Low Thyroid (hypothyroid)		Overactive Thyroid (hyperthyroid)	
Anxiety		Depression		Bi-Polar Disorder	
ADHD/ADD		Schizophrenia		Migraine Headaches	
Tension Headaches		Low Back Pain		Upper Back Pain	
Neck Pain		Hearing Loss/Hard of Hearing		Glaucoma	
Cataracts		Wears Glasses		Wears Dentures	
Eczema		Psoriasis		Breast Cancer	
Colon Cancer		Lung Cancer		Thyroid Cancer	
Skin Cancer		Brain Tumor		Bladder Cancer	
Brain Aneurysm		Abdominal Aneurysm		Arthritis	
Epilepsy		GERD/Heartburn/Reflux		Atrial Fibrillation (A-fib)	
Heart Attack		Congestive Heart Failure (CHF)		Alzheimer’s/Dementia	
Ankle Swelling (Edema)		Varicose Veins		Stroke (CVA)	
Diarrhea		Constipation		Prostate Disease	
Low Blood Pressure		Urine Leakage (Incontinence)		Hemorrhoids	
Liver Disease		Kidney Disease		Erectile Dysfunction	
PMS		Heavy Periods		PCOS	
Seasonal Allergies		TMJ (jaw problems)		HIV/AIDS	
Overweight/Obesity		Fibrocystic Breast Disease		Other:	
Other:		Other:		Other:	

Your Medications

Medication Name	Dose	Morning Pill	Lunch Pill	Dinner Pill	Bedtime Pill	Just As Needed

Reviewed by ____Date_________________________

Name____DOB____________________________

Your Medicine Allergies (check all that apply and indicate reaction)

Medication Name	**X**	**Reaction**
Penicillin/Amoxicillin		
Sulfa/Sulfur/Bactrim		
Zithromax/Azythromycin		
Erythromycin		
Clindamycin		
ACE Inhibitors (Lisinopril/Prinivil etc.)		
Statins (Cholesterol medicine)		
Codeine		
Oxycodone/Hydrocodone (Vicodin/Norco/Percocet)		
Morphine		
Sudafed (Pseudoephedrine)		
Other:		

Other:		
Other:		

Your Food Allergies:

Food	**X**	**Reaction**
Strawberries		
Milk/Dairy		
Wheat/Gluten		
Peanuts/Peanut Butter		
Other Nuts		
Shrimp/Shellfish		
Fish		
Eggs		
Soy		
Chocolate		
Other:		
Other:		

Environmental Allergies:

Allergen	**X**	**Reaction**
Dogs		
Cats		
Pollen		
Dust		
Grass		
Mold		
Other:		
Other:		

Reviewed by____Date___________________________

Name____DOB__________________________

May we share any vaccine information with the state/national immunization registry? [?] Yes [?] No

Do you have a living will or advanced directives (what you want done if you can't make medical decisions for yourself?

[?] Yes (please provide us with a copy)

[?] No Would you like information about this [?] Yes [?] No

Do you have a healthcare proxy (someone to make medical decisions for you if you are unable to do so?

[?] Yes (please provide us with a copy) Name____

[?] No Would you like information about this Yes No

Do you struggle to pay your bills? [?] Yes [?] No

Do you have food insecurity (trouble getting enough to eat for you and your family)? [?] Yes [?] No

Do you have transportation insecurity (trouble getting rides to where you need to go)? [?] Yes [?] No

Is your housing stable (are you at risk of being homeless)? [?] Yes [?] No

Is your home safe (enough heat, running water, proper lights, no broken steps or railings etc.) [?] Yes [?] No

Are you at risk for domestic abuse/violence? [?] Yes [?] No If yes, Would you like help? [?] Yes [?] No

Are there any other issues you would like to discuss with us? [?] Yes [?] No If yes, what? __________________________________

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We are required by the federal government to collect certain non-medical information. Please be aware that this information is optional for you to provide. This information may help us care for you better. When our practice provides this information to agencies requesting it, the format <u>does not</u> provide your name or personally identifiable information.

Race: [?] American Indian or Alaskian Native [?] Black or African American [?] Asian [?] Pacific Islander/Hawaiian [?] White

Ethnicity: [?] Hispanic or Latino [?] Non-Hispanic or Latino

Primary Language: [?] English [?] Spanish [?] Other____

Sexual Orientation: [?] Lesbian/Gay/Homosexual [?] Heterosexual/Straight [?] Bisexual [?] Other [?] Decline to Disclose

Gender Identity: [?] Female [?] Male [?] Transgender-Female to Male [?] Transgender-Male to Female [?] Gender Queer [?] Gender Fluid [?] Other [?] Decline to Disclose

Reviewed by____Date_________________________