SOUTH COAST FAMILY MEDICAL CENTER, INC.

MEDICAL HISTORY FORM

Name: ______________________ Date of Birth: __________ Today's date: __________

Preferred local pharmacy name and city: ______________________________

Mail order pharmacy name: ______________________________

MEDICATIONS ☐ I do not take any medications

*Please include prescription, over-the-counter (OTC), birth control, vitamins, herbal supplements.

Medication name	Dose	Frequency (how many and how often)

ALLERGIES (drug, food, latex) and reaction ☐ I do not have any allergies

Allergy	Reaction	Allergy	Reaction

CHRONIC MEDICAL PROBLEMS/YEARS OF ONSET

	Year		Year	
☐ Heart disease/heart attack	______	☐ Asthma	______	☐ Other: ______________
☐ High blood pressure	______	☐ Allergies/hay fever	______	______________
☐ High cholesterol	______	☐ Vascular disease	______	______________
☐ Diabetes	______	☐ Depression	______	______________
☐ Cancer	______	☐ Anxiety	______	______________

PRIOR SURGERIES AND HOSPITALIZATIONS / YEAR

______________________________ ______________________________

______________________________ ______________________________

FAMILY HISTORY ☐ Unknown ☐ Adopted

Please check if any family member has had any of the following conditions:

Family member	Good health	Heart disease (age of onset)	High BP (age of onset)	Stroke (age of onset)	Cancer & type (age of onset)	Other illness (age of onset)
Father						
Mother						
Sibling						
Paternal GM						
Paternal GF						
Maternal GM						
Maternal GF						

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www.southcoastfamilymed.com

SOUTH COAST FAMILY MEDICAL CENTER, INC.

MEDICAL HISTORY FORM (continued)

Name: ______________________ Date of Birth: ___________ Today's date: ___________

SOCIAL HISTORY

1. Highest level of education: ☐ high school ☐ college ☐ graduate ☐ post-graduate ☐ Other: ___________
2. Occupation: ______________________
3. Please describe your living situation: ______________________
4. Tobacco use: ☐ Never ☐ Current ☐ Former Cigarettes/day: ____ Yrs used: ____ Yr quit: ____
5. Alcohol use: ☐ Yes ☐ No ☐ Former Drinks/day: _____ ☐ Daily ☐ Social
6. Exercise/activity: ☐ Yes ☐ No Type: ___________ Days/wk: ____ Hours per week: _______
7. Religious preference: ______________________
8. Do you have an advanced directive? (legal documents that allow you to plan and make your own end-of-life wishes known in the event that you are unable to communicate.)
   ☐ None ☐ Advanced Health Care Directive ☐ Living Will

CONFIDENTIAL INFORMATION

Recreational drugs: ☐ No ☐ Yes ☐ Former Drug type/frequency: ______________

Do you have concerns for your safety? ☐ No ☐ Yes: ______________

Over the past 2 weeks often have you been bothered by any of the following problems?	Not at all	Several days	More than ½ the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed or hopeless.	0	1	2	3

PREVENTATIVE MEDICINE

Please list other physicians/health care providers you see and the reason you see them.

______________________ ______________________

______________________ ______________________

______________________ ______________________

Please list the last time you received the services below

Health maintenance exam and year		Immunizations and year
-Mammogram: _________,	normal? ☐ Yes ☐ No	-Influenza (flu): _______
-Pap: _______________,	normal? ☐ Yes ☐ No	-TD/Tdap (tetanus, whooping cough): _______
-Colonoscopy: _________,	normal? ☐ Yes ☐ No	-HPV (Gardasil): _______
-Bone density: _________,	normal? ☐ Yes ☐ No	-Shingles (Zostavax): _______
-Eye exam: ___________,	normal? ☐ Yes ☐ No	-Pneumonia (Pneumovax/Prevnar): _______

Reviewed by: ______________________ Date: ____/____/________
Provider's signature

☐ Dr. Chris Davis, D.O. ☐ Dr. Lauren Davis, D.O.
☐ Claire Dellegrotti, N.P.