

MedNow Clinic Ellsworth

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MEDICAL HISTORY FORM

Patient's Name: _____ Date: _____
Date of Birth: _____ Age: _____ Marital Status: M S W D
Parent's Name (if child): _____
Reason(s) for visit: _____

FAMILY INFORMATION:

Please check if any near relative had:

____ Asthma ____ Heart Disease ____ Convulsions ____ Strokes
____ Cancer ____ High Blood Pressure ____ Glaucoma
____ Diabetes ____ Kidney Disease ____ Nervous Troubles

AGE HEALTH (IF DECEASED - WHAT AGE & CAUSE?)

FATHER _____
MOTHER _____
SIBLINGS _____
CHILDREN _____

DO YOU HAVE THIS MEDICAL PROBLEM NOW OR HAVE YOU IN THE PAST:

<u>YES</u>	<u>YES</u>	<u>YES</u>
____ Recurrent Cough	____ Drug Allergy	____ Birth Control Pills
____ Coughing Blood	____ Black Stools	____ Eye Trouble
____ Pneumonia	____ Rectal Bleeding	____ Ear Trouble
____ Bronchitis	____ Jaundice (yellow skin)	____ Nose Trouble
____ Pleurisy	____ Hernia (rupture)	____ Throat Trouble
____ Hoarseness	____ Urine Sugar	____ Headaches
____ Sinusitis	____ Frequent Urination	____ Dizzy Spells
____ Tuberculosis	____ Burning on Urination	____ Convulsions
____ Chest Pain	____ Blood in Urine	____ Paralysis
____ Irregular Heart Beat	____ Awaken to Urinate	____ Numbness
____ Shortness of breath	____ Prostate Trouble	____ Mental Illness
____ Heart Trouble	____ Kidney Stones	____ Excessive Worry
____ High Blood Pressure	____ Venereal Disease	____ Unconsciousness
____ Leg Pains, Cramps	____ Back Trouble	____ Tumor or Cancer
____ Ankle Swelling	____ Arthritis	____ Anemia
____ Fainting Spells	____ Broken Bones	____ Weight Loss/Gain
____ Frequent Indigestion	____ Hay Fever	____ Skin Trouble
____ Trouble Swallowing	____ Asthma	____ Diabetes
____ Stomach Pain	____ Eczema	____ Breast Lump
____ Stomach Ulcer	____ Hives	____ Abnormal Periods
____ Change in Bowel Habits	____ Breast Discharge	Date of last period _____
		Date of last Pap Smear _____

Do you drink alcohol? _____, If yes, amount consumed? _____

Do you use tobacco products? _____, If yes, amount consumed? _____

What medications or prescribed drugs are you currently taking? _____

Are you allergic to any medications? _____

(EXAMINER MUST ELABORATE ON EACH POSITIVE ANSWER NOTED ABOVE.)