Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Aspirin		☐ Latex	
☐ Doxycycline		☐ Other:	
☐ Erythomycin		☐ Other:	
☐ Macrobid		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking)

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

VACCINES (Please check all vaccines that you have had & the date in which the vaccine was given)

Vaccine	**Date**	**Vaccine**	**Date**	**Vaccine**	**Date**
☐ Chicken Pox (Varicella)		☐ Meningococcal		☐ Tdap	
☐ DTaP/DTP		☐ Pneumococcal		☐ Tetanus	
☐ Hepatitis A		☐ Pneumovax		☐ Other:	
☐ Hepatitis B		☐ Polio		☐ Other:	
☐ HPV		☐ Rabies		☐ Other:	
☐ Influenza		☐ Shingles (Herpes Zoster)		☐ Other:	
☐ Measles/Mumps/Rubella		☐ Td (Adult) (tetanus & diphtheria)			

CHIEF COMPLAINT TODAY (Please check the reason for your visit today)

☐ Abdominal Pain (☐ Right ☐ Left)	☐ Frequent Urination/Possible UTI	☐ Pre-op
☐ Annual Physical	☐ Fatigue	☐ Post-op
☐ Anxiety	☐ Headache	☐ Shortness of Breath
☐ Asthma	☐ Heartburn/Indigestion	☐ Skin Rash/Problem
☐ Back Pain (☐ Right ☐ Left)	☐ Hyperlipidemia	☐ Sleep Problems
☐ Blood Pressure	☐ Knee Pain (☐ Right ☐ Left)	☐ Sore Throat
☐ Chest Pain	☐ Medicare Annual Well Visit	☐ Other:
☐ Cough	☐ Nasal Congestion	☐ Other:
☐ Depression	☐ Neck Pain	☐ Other:
☐ Diabetes	☐ Palpitations	☐ Other:

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PAST MEDICAL HISTORY (Please check those items that apply)

☐ ADD or ADHD	☐ COPD	☐ Lymphoma
☐ Allergies	☐ CVA- Cerebrovascular Accident	☐ Myocardial Infarction
☐ Alzheimer's Disease	☐ Deep Vein Thrombosis	☐ Narcolepsy
☐ Anemia	☐ Dementia	☐ Neurologic Disorder
☐ Anxiety Disorder	☐ Depression	☐ Obesity, Morbid
☐ Aortic Aneurysm	☐ Diabetes	☐ Osteoarthritis
☐ Arrhythmia	☐ Diverticulitis	☐ Osteoporosis
☐ Arthritis	☐ Eczema, Hives or other skin conditions	☐ Ovarian Cyst Uterine Fibroids PID
☐ Asthma	☐ ED- Erectile Dysfunction	☐ Pacemaker
☐ Atrial Fibrillation	☐ Endometriosis	☐ Parkinsonism
☐ Bipolar	☐ Fibromyalgia	☐ Peptic Ulcer
☐ Blood Clot	☐ GERD/Reflux	☐ Peripheral Arterial Disease
☐ BPH- Benign Prostatic Hyperplasia	☐ Glaucoma	☐ Psychiatric Problems/Illness
☐ Breast Cancer	☐ Gout	☐ PTCA with stent CABG
☐ Cancer, Brain	☐ Headaches or Migraines	☐ Pulmonary Embolism
☐ Cancer, Lung	☐ Hypertension	☐ Restless Leg Syndrome Snoring
☐ Cancer, Cervical	☐ Heart Disease	☐ Pyelonephritis
☐ Cancer, Colon	☐ Hepatitis	☐ Raynaud's Syndrome
☐ Cancer, Esophagus	☐ High Cholesterol	☐ Renal Stones
☐ Cancer, Ovarian	☐ Hypothyroidism	☐ Rheumatoid Arthritis
☐ Cancer, Prostate	☐ IBS	☐ Seizures/Epilepsy
☐ Cancer, Skin, Melanoma	☐ Inflammatory Bowel Disorder	☐ Sleep Apnea
☐ Cancer, Uterine	☐ Insomnia	☐ Sleep Disorder
☐ Cardiomyopathy	☐ Kidney Disease	☐ Stroke
☐ Carotid Disease	☐ Kidney Stones	☐ Thyroid Disease
☐ Chronic Fatigue Syndrome	☐ Liver Disease	☐ TIA
☐ Congestive Heart Failure (CHF)	☐ Lupus-Systemic Lupus Erythematosis	☐ Valvular Heart Disease
☐ Other:	☐ Other:	☐ Other:
☐ Other:	☐ Other:	☐ Other:

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ Abdominal Surgery		☐ Cataract Surgery	
☐ Adenoid Surgery		☐ Colonoscopy	
☐ AICD		☐ Colposcopy	
☐ Amputation		☐ Coronary Artery Stent	
☐ Angioplasty		☐ Dilation and Curettage	
☐ Appendectomy		☐ Ear Tube	
☐ Arthroscopic Surgery		☐ Ectopic Pregnancy	
☐ Back Surgery		☐ Endometrial Ablation	
☐ Breast Biopsy		☐ Eye Surgery	
☐ Breast Implants		☐ Flexible Sigmoidoscopy	
☐ Breast Surgery		☐ Gastric Bypass	
☐ Bronchoscopy		☐ Gastric Surgery	
☐ CABG		☐ Gastrointestinal Surgery	
☐ Caesarean Section		☐ Genitourinary Surgery	
☐ Cancer Surgery		☐ HEENT Surgery	
☐ Cardiac Catheterization		☐ Hemorrhoidectomy	
☐ Cardiac Surgery		☐ Hernia Repair	
☐ Cardioversion		☐ Hydrocele Repair	
☐ Carotid Endarterectomy		☐ Hysterectomy	
☐ Cholecystectomy		☐ Hysteroscopy	
☐ Joint Replacement		☐ Rhinoplasty	
☐ Knee Surgery		☐ Septoplasty	
☐ Laparoscopy		☐ Splenectomy	
☐ Laparotomy		☐ Stent	
☐ LEEP		☐ Strabismus Surgery	
☐ Lumpectomy		☐ Thyroid Surgery	
☐ Mastecomy		☐ Tonsillectomy	
☐ Myomectomy		☐ Tonsillectomy Adenoidectomy	
☐ Oophorectomy		☐ Total Abdominal Hysterectomy	
☐ Orthopedic Surgery		☐ Tracheostomy	
☐ Ovarian Cystectomy		☐ Tubal Ligation	
☐ Pacemaker		☐ Vascular Surgery	
☐ Prostate Surgery		☐ Vasectomy	

Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY *continued* (Please check previous surgeries that you have had, including date)

☐ Reconstructive Surgery		☐ Other:	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Allergy			
☐ Alzheimer's Disease			
☐ Anemia			
☐ Angina (Heart Problems)			
☐ Anxiety Disorder			
☐ Arthritis			
☐ Asthma			
☐ Blood Coagulation Disorder			
☐ Cerebrovascular Accident			
☐ Chronic Obstructive Pulmonary Disease (COPD)			
☐ Coronary Artery Disease			
☐ Deep Venous Thrombosis (DVT)			
☐ Dementia			
☐ Depressive Disorder (Depression)			
☐ Developmental Disorder			
☐ Diabetes Mellitus (Diabetes)			
☐ Disease of Liver (Liver Problems)			
☐ Disorder of Endocrine System (Endocrine Problems)			
☐ Disorder of Nervous System (Neurologic Problems)			
☐ Disorder of Thyroid Gland (Thyroid Problems)			
☐ Endometrial Carcinoma (Endometrial Cancer)			
☐ Heart Attack (MI)			
☐ Heart Disease			
☐ Heart Failure			
☐ Hypercholesterolemia (High Cholesterol)			
☐ Hypertensive Disorder (Hypertension)			
☐ Immunodeficiency Disorder (Immune Problems)			
☐ Kidney Disease			
☐ Leukemia			
☐ Malignant Lymphoma -clinical (Cancer)			
☐ Malignant Neoplasm of Uterus (Uterine Cancer)			
☐ Malignant Tumor of Breast (Breast Cancer)			
☐ Malignant Tumor of Cervix (Cervical Cancer)			
☐ Malignant Tumor of Colon (Colon Cancer)			
☐ Malignant Tumor of Kidney (Kidney Cancer)			
☐ Malignant Tumor of Lung (Lung Cancer)			
☐ Malignant Tumor of Ovary (Ovarian Cancer)			
☐ Malignant Tumor of Pancreas (Pancreatic Cancer)			
☐ Malignant Tumor of Prostate (Prostate Cancer)			
☐ Mental Disorder (Mental Illness)			
☐ Migraines (Headaches)			
☐ Myocardial Infarction			
☐ Obesity			
☐ Osteoporosis			
☐ Parkinson's Disease			
☐ Psychiatric Problems			
☐ Pulmonary Disease			
☐ Rheumatoid Arthritis			
☐ Seizure Disorder (Epilepsy/Seizures)			
☐ Sleep Apnea			
☐ Substance Abuse (Alcoholo/Substance)			
☐ Sudden Cardiac Death			
☐ Thyroid Problems			
☐ Tuberculosis			
☐ Varices			
☐ Other:			
☐ Other:			

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SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Prefer Not to Discuss

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Illicit Drugs: _____

Seat belts used routinely: ☐ Yes ☐ No Sunscreen used routinely: ☐ Yes ☐ No

GYN HISTORY (*Women Only)*

Duration of Flow _____(days) Frequency of Cycle _____(Q days)

Menses Monthly: ☐ Yes ☐ No Flow: ☐ Light ☐ Moderate ☐ Heavy

Age at First Child: _____ Age at Menarche: _____

Current Birth Control Method: ☐ None ☐ BCPs ☐ Sterilization ☐ Tubal Ligation ☐ IUD ☐ Condoms ☐ Partner Vasectomy ☐ Unknown ☐ Depo-Provera ☐ Vaginal Ring ☐ Hysterectomy ☐ Abstinence ☐ Diaphragm ☐ Seeking Pregnancy ☐ Implant ☐ Patch ☐ Multiple Methods ☐ Menopause ☐ Spermicide ☐ Pregnant ☐ Withdrawal ☐ Fertility Awareness Method ☐ Ablation ☐ Fertility Issues ☐ Breastfeeding/LAM ☐ Emergency Contraception ☐ Sponge ☐ Cervical Cap ☐ Other: _____

On BCP's at Conception? : ☐ Yes ☐ No HPV Vaccine: ☐ Yes ☐ No

If Post Menopausal, Age at Menopause: _____

Abnormal Pap: ☐ Yes ☐ No Date of Last Pap Smear: _____

Date of Most Recent Bone Density:_____ Date of Most Recent Mammogram: _____

Sexually Active? : ☐ Yes ☐ No STIs/STDs: ☐ Yes ☐ No