Family Medicine Associates
Medical History Form

Name _____
Address _____
_____
Zip Code _____
Emergency Contact_____
_____
Date of Birth _____ Age __ Sex __M __F
Social Security Number _____
Regular Medical Doctor_____
Phone – Home_____ Work_____
Cellular _____
Email _____

When did you last consult a MD?
_____

Have you ever had problems with the following systems?

Ear,Nose,Throat _____
Heart _____
Lung _____
Stomach,Intestine_____
Kidney,Bladder,Prostate_____
Bones ,Joints _____
Brain,SpinalCord,Back _____
Skin _____
Male,Female organs _____
Mental Health _____
Endocrine (Thyroid,Diabetes,etc) _____

Hospitalizations _____
_____
_____
_____
_____

Surgery _____
_____

Injuries _____

Serious Medical Illness _____
_____

Allergies _____

Immunizations
Influenza ____Tetanus ____Pneumonia ____Shingles_____
Do you have a Health Care Proxy? Y__ N__
Do you have a Living Will? Y__ N__
Medications_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signed _____ Date _____