Olympia Multi-specialty Clinic

Medical History Form

Date _____/_____/_____ Account # ____________

Name _______________________________________ Birth Date _____/_____/_____ Age____ ☐M ☐F

Medications

Name	Dose	Times Taken	Prescribing Provider

Allergies

Name	What happened? (examples: rash, hives, nausea)

Symptoms that you have. Check all that apply.

General
- ☐ Fatigue
- ☐ Weight loss
- ☐ Fever
- ☐ Night Sweats

Blood
- ☐ Bruise easily
- ☐ Anemia
- ☐ Bleeding

Endocrine
- ☐ Feel cold often
- ☐ Feel hot often
- ☐ Sexual dysfunction

Lungs
- ☐ Short of breath
- ☐ Wheezing
- ☐ Cough

Skin
- ☐ Rash, hives
- ☐ Itching

Heart
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swollen legs, ankles
- ☐ Trouble breathing at night
- ☐ Fainting, blackouts
- ☐ Leg pain when walking

Gastrointestinal
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal bleeding
- ☐ Rectal pain
- ☐ Jaundice

Urinary Tract
- ☐ Pain when urinating
- ☐ Difficulty Urinating
- ☐ Blood in Urine

Eyes/Ears/Nose
- ☐ Ringing in ears
- ☐ Poor vision
- ☐ Nasal congestion
- ☐ Snoring

Nervous System
- ☐ Headaches
- ☐ Seizures
- ☐ Numbness
- ☐ Loss of memory
- ☐ Weakness arm, leg

Bones/Joints
- ☐ Joint pain _________
- ☐ Back pain
- ☐ Muscle aches

Please continue on the backside of this form

Problems or Conditions that you have. Check all that apply.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart Attack
- ☐ Heart valve condition
- ☐ Irregular heart rhythm
- ☐ Heart stent
- ☐ Stroke
- ☐ Heart failure
- ☐ Blood clots
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Asthma
- ☐ COPD, emphysema
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Ulcers
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Cancer ______________
- ☐ Rheumatic fever
- ☐ Hepatitis
- ☐ Colon polyps
- ☐ Kidney infections
- ☐ Other _______________
- ☐ Other _______________

Family History

	Father	Mother	Brother	Brother	Sister	Sister
Age of Death						
Heart Attack						
Hypertension						
Heart Bypass						
Stroke						
Cancer						
Diabetes						
Colon Polyps						
Liver Disease						
Gallbladder						

Surgeries - Year

- ☐ Gallbladder __________
- ☐ Tonsils __________
- ☐ Appendix __________
- ☐ Heart Bypass__________
- ☐ Heart Valve __________
- ☐ Heart Stent
- ☐ Hysterectomy_________
- ☐ Ovaries __________
- ☐ Back __________
- ☐ Breast __________
- ☐ Knee _______________
- ☐ Hip _______________
- ☐ Other _______________
- ☐ Other _______________

Tobacco ☐Y ☐N

- ☐ Cigarettes _____packs/day
- ☐ Chewing tobacco
- ☐ Cigars ________number/day

Alcohol ☐Y ☐N

- ☐ Beer _____ per day
- ☐ Wine _____ glasses per day
- ☐ Liquor ____ ounces per day

Coffee ☐Y ☐N

- ☐ Caffeinated ______ cups per day
- ☐ Decaffeinated ____ cups per day

Routine Health Care - Date last

- ☐ Stool test for blood _____________
- ☐ Mammogram _____________
- ☐ PAP smear _____________
- ☐ Chest X Ray _____________
- ☐ Sigmoidoscopy _____________
- ☐ Colonoscopy _____________
- ☐ Treadmill _____________
- ☐ EKG _____________
- ☐ PSA, prostate _____________

Reason for your visit ____

Family Physician ____

Referring Provider ____

Other Specialists 1) ______________________________2) ______________________________

3) ______________________________4) ______________________________