



# SW Durham Family Medicine, PLLC

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## Medical History Form

Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Age \_\_\_\_\_

Name \_\_\_\_\_

### Medications *including Dietary Supplements*

Name	Dose	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Medical Problems / Surgeries / Hospitalizations** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Family History *Any blood relative*

- |   |   |   |
|---|---|---|
| <input type="radio"/> heart disease       | <input type="radio"/> cancer                      | <input type="radio"/> seizures          |
| <input type="radio"/> high blood pressure | <input type="radio"/> depression / mental illness | <input type="radio"/> blood clots       |
| <input type="radio"/> thyroid disease     | <input type="radio"/> stroke                      | <input type="radio"/> kidney disease    |
| <input type="radio"/> diabetes            | <input type="radio"/> lung problems               | <input type="radio"/> bleeding problems |

### Health problems in immediate family

Mother	Father	Siblings
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Please list dates of your last

Cholesterol test \_\_\_\_\_ Pneumonia shot \_\_\_\_\_ Tetanus shot \_\_\_\_\_  
 Flexible sigmoidoscopy / Colon cancer screening \_\_\_\_\_

#### Women

Pap smear \_\_\_\_\_

Mammogram \_\_\_\_\_

#### Men

Prostate cancer screening \_\_\_\_\_

continue on back >

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**Lifestyle**

Ever use tobacco?  Yes  No Date stopped if no longer using \_\_\_\_\_

Currently using chewing tobacco, snuff, pipe or cigarettes?  Yes  No

Alcohol use:  More than one drink per day  Less than one drink per day  Never

Caffeine use:  More than two drinks per day  Two drinks or less per day  Never

Recreational drugs (marijuana, cocaine, etc.) \_\_\_\_\_

Sexual preference  Men  Women  Both

Live by myself  Live with \_\_\_\_\_

Do you have any special requests due to religious practices / culture / values?

Education \_\_\_\_\_ Occupation \_\_\_\_\_

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**I currently have the following****Skin**

- Rash
- Sores
- Moles to check

**Eyes**

- Blurry vision
- Drainage from eyes
- Double vision

**Ears**

- Loss / Decrease of hearing
- Drainage from ears
- Ringing
  
- Sores in mouth
- Sinus problems / Hay fever

**Lung / Breathing**

- Cough
- Difficulty breathing
- Coughing up blood
- Wheezing

**Heart / Circulation**

- Heart murmur
- Chest pain
- Swollen ankles
- Leg pain when walking

**Skeleton**

- Pain in joints
- Stiffness in joints
- Swollen joints
- Back problems

**Digestive**

- Change in appetite
- Change in weight
- Problems with swallowing
- Indigestion / Heartburn
- Food intolerances
- Diarrhea
- Constipation
- Abdominal pain
- Bloody or black stool
- Vomiting
- Nausea

**Urinary**

- Difficulty Urinating
- Discomfort while urinating
- Incontinence/Accidents
- Urinating frequently or getting up more than one time at night
  
- Sexual problem

**Nervous system**

- Increase in headaches
- Loss of consciousness or faintness
- Sleep disturbance
- Depressed mood or anxiety
- Trouble with speech, balance, coordination or weakness
- Tingling in arms or legs

**Women**

- Heavy or painful periods
- Bleeding between periods
- Vaginal discharge more than usual
- Periods more/less than monthly
- Hot flashes
- Past menopause

Last menstrual period \_\_\_\_\_

Birth control \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

Children born alive \_\_\_\_\_

Miscarriages \_\_\_\_\_

Complications with pregnancy \_\_\_\_\_

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