

The Memphis Medical Society

COMPLIMENTARY PERSONAL HEALTH RECORD

This **Medical History Form** is provided as a resource for your individual, personal record keeping. As a patient, you may see many different doctors. It can be very helpful to your doctors and caregivers to have a one page list of:

1. Names, addresses and phone numbers of your doctors.
 2. Names of medications you are currently taking.
 3. Medical problems you have been diagnosed with, such as high blood pressure or diabetes.
-

This form will serve as a dynamic document for patients to continually update and chart their ongoing and changing medical history. The following information is essential for a physician's staff to provide care in a manner that is compatible with your general health.

This personal health record is provided to you for your convenience only. Entering information into this document does not guarantee that any physician will see it. This form should not be used as a substitute for directly communicating with your physician.

It is important that you provide accurate information so the physician may provide you safe and efficient treatment. Incorrect information can be dangerous to your health. If you have any questions regarding the following information, please consult your physician.

You can print and maintain a paper copy of your personal health record for your files and are strongly encouraged to do so each time you update this record. Neither The Memphis Medical Society, nor any physician affiliated with this organization assumes any liability whatsoever for your personal health record.

Section A: Patient Demographic Information

Title: _____ First Name: _____ Middle Name: _____
(Mr., Ms., Mrs., Dr., etc.)

Last Name: _____ Suffix: _____
(Jr., Sr., M.D., etc.)

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
(mm/dd/yyyy)

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Gender: _____ Male _____ Female

Street Address: _____ Apt # _____

City: _____ State: _____ Zip _____

Contact Information:

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ ext: _____

Cell Phone: (_____) _____ - _____ Email: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Emergency Contact: _____ Phone: _____

Who referred you to our Practice ?- _____ May we contact them ? _____

Section B: Medical History

Your Doctors' List (please, fill)

I don't have a physician (please, circle if true)

Name of Physician: _____ For care of: _____ Phone number _____

Name of Physician: _____ For care of: _____ Phone number _____

Name of Physician: _____ For care of: _____ Phone number _____

**Please list ALL the medications you are taking
(including any over-the-counter, vitamins, or herbal remedies):**

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

Name: _____ Dosage: _____ How often: _____

The following is a list of the top twenty (20) medications currently in use in the United States. Please circle ALL of the following that you are taking:

- | | | | |
|------------|---------------------|--------------------|-----------|
| Albuterol | Alprazolam | Amoxicillin | Atenolol |
| Furosemide | Hydrochlorothiazide | Hydrocodone w/APAP | Ibuprofen |
| Levoxyl | Lipitor | Lisinopril | Norvasc |
| Premarin | Prevacid | Synthroid | Toprol XL |
| Zithromax | Zocor | Zoloft | Zyrtec |

Have you ever had an allergic reaction to any medication? _____ Yes _____ No

**Please circle any of the following that you have had a drug allergy to
AND the nature of the reaction-**

- | | | |
|---------------------------------|-------------------|-----------------------|
| ACE inhibitors | Anticonvulsants | Aspirin |
| Beta blocker | Cefaclor (Ceclor) | Codeine / hydrocodone |
| Ibuprofen, Aleve | Insulin | IV contrast / Iodine |
| Multiple Antibiotic Sensitivity | | Penicillin |

Sulfa drugs **Other Medication(s)** - _____

Have you had any serious illnesses or operations in the last five years? _____ Yes _____ No

If yes, please describe and explain: _____

Have you ever had a blood transfusion? _____ Yes _____ No If yes, list dates: _____

Blood type: (circle one, if known) O+ A+ B+ AB+ O- A- B- AB-

Have you ever had a reaction to local anesthetic? ____ Yes ____ No If yes, please describe: ____

WOMEN ONLY:

Are you pregnant? ____ Yes ____ No ____ Maybe Nursing? ____ Yes ____ No

Are you taking birth control pills? ____ Yes ____ No

Please circle any of the following that you have been treated for:

AIDS	Alzheimer's Disease	Anaphylaxis	Anemia
Angina	Artificial heart valves	Artificial joints	Allergies
Asthma	Arthritis	Back Problems	Blood Disease
Cancer	Circulatory problems	Colitis	Congenital heart lesions
Crohn's Disease	Diabetes Type I	Diabetes Type 2	Emphysema
Epilepsy	Food allergies	Gastritis	Glaucoma
Gout	Headaches	Heart murmur	Hemophilia
Herpes	Hepatitis (indicate type: ____)		High blood pressure
HIV	Kidney disease	Liver disease	Mitral valve prolapse
Mononucleosis	Muscle Disorder	Nervous problems	Pace maker
Psychiatric care	Radiation treatment	Rheumatic fever	Staff infections
Strep Throat	Stroke	Surgical implants (indicate type: ____)	
Thyroid disease	Tuberculosis	Ulcer/colitis	Venereal disease

WOMEN ONLY:

Abnormal PAP	Breast mass or cyst	Endometriosis	Fibroids
Irregular periods	Menopause	Miscarriage	Ovarian cysts
Postpartum depression		Toxemia	Tubal pregnancy

Section C: Personal Lifestyle Information

Do you smoke? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No If yes, how many in an average week? ____

Do you use recreational drugs? ____ Yes ____ No If yes, which ones? _____

Do you have a history of domestic violence or sexual abuse? ____ Yes ____ No

Do you exercise regularly? ____ Yes ____ No

Is there anything else that you feel we should know? _____
