ARCADIA
MEDICAL

MEDICAL HISTORY

Patient Name:_____ Age:_____

Date of Birth:_____ Gender:_____ Race/Ethnicity:_____

Home Address:_____

Phone#:_____ Email:_____

Allergies

Class	Substance/Drug	Reaction
Medications		
Environmental		
Shellfish or Iodine		
Other		

Immunizations

Vaccine	Date Received
Annual Influenza (Flu shot)	
TDAP or Tetanus Booster	
Zoster Vaccine Live (ZVL) or Recombinant Zoster Vaccine (RZV)	
Pneumococcal (PVC13 and PCV23)	

Preventative Screening Tests and Health Maintenance

Test	Most Recent Date	Results
Last Dental Exam		
Colonoscopy		
Mammogram		
Prostate Specific Antigen (PSA)		
Chest CT for Lung Nodules		
Abdominal Ultrasound		
Bone Mineral Density Scan (DEXA)		
PAP Smear		

Current Medications

Prescription Medications:

Name	Dose	Frequency	Reason

Over the Counter Medications:

Name	Dose	Frequency	Reason

Dietary Supplements, Vitamins, Herbs:

Name	Dose	Frequency	Reason

Implanted Medical Devices: *(IUD, Nexplannon, heart stents, pacemaker, ICD, spinal stimulators, etc.)*

Name of Device	Reason

Past Medical History

1. Have you ever been diagnosed with any of the following?

☐ High Blood Pressure
☐ Diabetes
☐ High Cholesterol
☐ Asthma
☐ COPD or Emphysema
☐ Pneumonia
☐ Thyroid Problems
☐ Heart Murmur
☐ Heart Attack (MI)
☐ Rheumatic Fever
☐ Heart Valve Disorder
☐ Crohn's or Ulcerative Colitis
☐ Anemia
☐ Cancer (of any kind)
☐ Arthritis
☐ Glaucoma
☐ Cataracts
☐ Vision Problems
☐ Hearing Loss
☐ Epilepsy or Seizures
☐ Migraines or Headaches
☐ Hepatitis
☐ Stomach Ulcers
☐ Varicose Veins
☐ Kidney Stones
☐ Urinary Infections (UTI)
☐ Hernia
☐ Erectile Dysfunction
☐ Sexually Transmitted Disease
☐ Skin Disorder
☐ Polio
☐ Broken Bones
☐ Depression
☐ Anxiety
☐ Blood Clots
☐ Gallbladder Problems

Other diagnoses:_____

2. Have you been exposed to any of the following environmental, occupational or industrial hazards for an extended period of time?

☐ Asbestos
☐ Carbon Monoxide
☐ Metals (Lead, Mercury, Cadmiun, Copper, Nickel)
☐ Second Hand Smoke
☐ Plastic Fumes
☐ Pesticides
☐ Fertilizers
☐ Silica Dust
☐ Hair Product Chemicals
☐ Radiation

Hospitalizations

Date	Reason	Hospital/Location

Surgeries

Date	Type of Surgery/Reason	Surgeon/Hospital

Family History

Relative	Alive or Deceased?	Age	Medical Conditions
Mother			
Father			
Siblings:			
Children:			

Social History

1. Tobacco use:

Do you currently use or have you ever used any of the following tobacco or nicotine containing products?

☐ Cigarettes:_____ packs per day ☐ Chewing tobacco ☐ Vaporizers or e-cigs

What age did you begin smoking or using tobacco products? _____

2. Alcohol use (AUDIT-C):

How often do you have a drink containing alcohol?

☐ Never ☐ 2-4 times a month ☐ 4+ times a week
☐ Once a month or less ☐ 2-3 times a week

How many drinks containing alcohol do you have on a typical day?

☐ 1 or 2 ☐ 5 or 6 ☐ 10 or more
☐ 3 or 4 ☐ 7-9

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Monthly ☐ Daily or almost daily
☐ Less than monthly ☐ Weekly

3. Marijuana use:

How often do you use marijuana?

☐ Never ☐ Monthly ☐ Daily or almost daily
☐ Less than monthly ☐ Weekly

4. Caffeine use:

How many caffeinated beverages do you consume a day?

☐ None ☐ 3-4

☐ 1-2 ☐ More than 4

5. Have you ever used an illegal drug or prescription medication for nonmedical reasons?

☐ Yes ☐No

If yes, do you use more then one drug at a time? ☐ Yes ☐No

Are you always able to stop using drugs when you want to? ☐ Yes ☐No

Have you ever had blackouts or flashbacks as a result of drug use? ☐ Yes ☐No

Do you ever feel guilty about your drug use? ☐ Yes ☐No

6. Occupation:_____

7. Highest level of education achieved:

☐ Elementary ☐ Bachelor's Degree

☐ Middle school ☐ Master's Degree

☐ High School Diploma ☐ Doctorate's Degree

☐ Associate's Degree

8. Marital status:

☐ Single ☐ Divorced

☐ Married ☐ Widowed

9. Religious / Spiritual Background:

Do you consider yourself to be religious or spiritual? ☐ Yes ☐No

What helps you most when things are difficult or when times are hard? _____

_____

10. Exercise:

What activities do you enjoy performing for exercise? _____

How many days per week do you exercise?

☐ 0 ☐ 3-4 days

☐ 1-2 days ☐ Most days

Average duration of each exercise: _____

11. Diet:

For an average meal, how much of your plate does each food group take up?

Breakfast					
	0%	25%	50%	75%	100%
Fruits/Vegetables					
Starch/Grains					
Meat/Protein					
Dairy					
Sweets/Sugar					

Lunch					
	0%	25%	50%	75%	100%
Fruits/Vegetables					
Starch/Grains					
Meat/Protein					
Dairy					
Sweets/Sugar					

Dinner					
	0%	25%	50%	75%	100%
Fruits/Vegetables					
Starch/Grains					
Meat/Protein					
Dairy					
Sweets/Sugar					

How often do you cook meals at home?

☐ Never ☐ 3-4 days per week ☐ Every day

☐ 1-2 days per week ☐ 5- 6 days per week

12. Intimate partner violence:

Are you currently or have you ever been in a relationship where your partner has…

Pushed or slapped you? ☐Yes ☐No
Threatened you with violence? ☐Yes ☐No
Thrown, broken, or punched things? ☐Yes ☐No

13. Psychiatric- Depression Screening (PHQ-9):

Over the past 2 weeks how often have you felt bothered by any of the following problems?

	Not at all	Several Days	More than half days	Nearly Everyday
Little interest or pleasure doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself or that you are a failure or have let yourself or your family/ friends down	**0**	**1**	**2**	**3**
Trouble concentrating on things such as reading or watching TV	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people have noticed	**0**	**1**	**2**	**3**
Thoughts of hurting yourself, or that you would be better off dead	**0**	**1**	**2**	**3**

If you experience any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Very difficult
☐ Somewhat difficult ☐ Extremely difficult

14. Sexual History- STD Risk Assessment:

Are you currently sexually active? ☐ Yes ☐No

How many sexual partners have you had over the past 12 months? _____

What gender(s) are your sexual partners? _____

What form(s) of protection from STDs do you and your partner(s) use? _____

How often do you use protection? ☐ Always ☐ Most times ☐ Rarely ☐ Never
Have you or your partner ever been diagnosed with an STD? ☐ Yes ☐No
Would you like to be tested for an STD and/or HIV? ☐ Yes ☐No

Are you and your partner trying to conceive? ☐ Yes ☐No
If no, what forms of contraception are you currently using? _____
Do you need any information on methods of birth control? ☐ Yes ☐No

15. Female Obstetrics and Gynecology:

Number of pregnancies:_____
Live births: _____
Miscarriages or abortions: _____
Age of first menstrual period: _____
Date of last menstrual period: _____
How often are your cycles?_____
How many days do they last? _____
If in menopause, age of onset: _____

16. Breast Cancer Risk Assessment (Gail Risk Model)

For women of the ages 35 through 85:
Age: _____
Age of first menstrual period: _____
Age of first live birth: _____
Number of first degree relatives with breast cancer (mothers, sisters, daughters): _____
Number of previous breast biopsies : _____
Race/Ethnicity: _____

17. Fracture Risk Assessment (FRAX)

For patients of the ages 40 through 90:
Age:_____ Gender: _____ Weight: _____ Height: _____

Previous fracture:	☐ Yes	☐No
Previous hip fracture:	☐ Yes	☐No
Current smoker:	☐ Yes	☐No
Systemic (oral) corticosteroid use for more than 3 months:	☐ Yes	☐No
Rheumatoid arthritis:	☐ Yes	☐No
Secondary risk factors for osteoporosis:	☐ Yes	☐No

ex: Insulin dependent diabetes, Osteogenesis imperfecta, chronic hyperthyroidism, hypogonadism, premature menopause (<45yo), chronic malnutrition, chronic liver disease

3 or more standard drinks of alcohol a day:	☐ Yes	☐No

Femoral neck BMD (g/cm2) from recent DXA scan: _____

18. Benign Prostatic Hypertrophy Screening

For men, circle the option that describes you best:

Over the past month...						
How often have you had the sensation of not completely emptying your bladder after you finish urinating?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
How often have you had to urinate again less than 2 hours after you finished urinating?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
How often have you found that you stopped and started again when urinating?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
How often have you found it difficult to postpone urination?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
How often have you had a weak urinary stream?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
How often have you had to push or strain to begin urinating?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
How many times do you typically need to get up to urinate in the middle of the night?	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
Score	**0**	**1**	**2**	**3**	**4**	**5**

Total Score: _____

19. Erectile Dysfunction Screening:

For men, circle the option that describes you best:

Over the past 6 months...						
How do you rate your confidence that you could get and keep an erection?	**None**	**Very low**	**Low**	**Moderate**	**High**	**Very High**
When you had erections with sexual stimulations, how often were your erections hard enough to penetrate?	**Did not attempt intercourse**	**Never or almost never**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	**Did not attempt intercourse**	**Never or almost never**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always**
During sexual intercourse how difficult was it to maintain your erection to the completion of intercourse?	**Did not attempt intercourse**	**Never or almost never**	**Very difficult**	**Difficult**	**Slightly difficult**	**Not difficult**
When you attempted sexual intercourse, how often was it satisfactory for you?	**Did not attempt intercourse**	**Never or almost never**	**Less than half the time**	**Half the time**	**More than half the time**	**Almost always or always**
Score	**0**	**1**	**2**	**3**	**4**	**5**

Total Score: _____

Review of Systems

Have you recently or are you currently experiencing any of the following symptoms?

General:
☐ Fever, Chills
☐ Fatigue
☐ Recent weight loss
☐ Recent weight gain
☐ Weakness

Head:
☐ Recent head trauma
☐ Headaches/ Migraines
☐ Dizziness
☐ Lightheadedness

Eyes:
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double vision
☐ Flashing spots
☐ Floaters

Ears:
☐ Ringing in ears
☐ Loss of hearing
☐ Drainage from ear
☐ Pain

Nose:
☐ Nose bleeds
☐ Loss of smell
☐ Runny nose
☐ Stuffy nose
☐ Sneezing

Mouth / Throat:
☐ Tooth pain
☐ Jaw pain/ Clicking/ Snapping
☐ Sore tongue
☐ Mouth sores
☐ Bleeding gums
☐ Hoarseness
☐ Difficulty swallowing

Neck:
☐ Whiplash/ Neck trauma
☐ Neck pain/ stiffness
☐ Swollen lymph nodes/ glands

Chest/ Breasts:
☐ Self- breast exams?
☐ Lumps or masses
☐ Nipple discharge
☐ Rash on breast
☐ Nipple pain/ tenderness

Respiratory:
☐ Difficulty breathing
☐ Shortness of breath
☐ Wheezing
☐ Cough
☐ Pain with breathing

Cardiovascular:
☐ Chest pain
☐ Irregular heart beat
☐ Heart murmur
☐ Swelling in legs/arms
☐ Cramping in legs
☐ Varicose veins

Gastrointestinal:
☐ Abdominal pain
☐ Nausea or Vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in stool
☐ Black tarry stool
☐ Heartburn
☐ Yellow skin

Genitourinary:
☐ Difficulty urinating
☐ Poor stream or dribbling
☐ Incontinence
☐ Pain with urination
☐ Blood in urine
☐ Frequent urination
☐ Burning urination
☐ Painful intercourse

Male Reproductive:
☐ Genital sores or rashes
☐ Scrotal mass or swelling
☐ Penile discharge
☐ Difficulty with erections

Female Reproductive:
☐ Unusual discharge or odor
☐ Sores or rashes
☐ Excessive cramping or bleeding
☐ Postmenopausal bleeding
☐ Vaginal dryness
☐ Hotflashes or night sweats
☐ Painful intercourse

Musculoskeletal:
☐ Joint pain or swelling
☐ Muscle pain or cramps
☐ Back pain

Neurological:
☐ Numbness or tingling
☐ Loss of consciousness
☐ Memory loss
☐ Balance problems

Skin:
☐ Rash
☐ Change in hair or nails
☐ Lumps, growths, wounds

Endocrine:
☐ Excessive hunger or thirst
☐ Hot or cold intolerance
☐ Change in shoe or glove size

Psychological:
☐ Anxiety or Depression
☐ Mood swings