



ADVANCED SPECIALTY CARE

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GENERAL HEALTH HISTORY – Dr. Maddox

Patient Name: _____ Date: _____
 Date of Birth: _____ Age: _____ Sex: M F
 Primary Care Doctor: _____ Primary Pharmacy: _____
 Occupation: _____ Current Employer: _____
 Last grade of school completed: _____

What is your main reason for making this appointment? _____

Medications

Medication Name	Strength (mg, etc.)	How often taken	Prescribing Doctor

Drug Allergies

Medication Name	Reaction

Past Medical History: If you have ever had any of the following medical conditions, please check them and write in the appropriate date that you were first told you had the problem.

- | | |
|---|---|
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Hepatitis: _____ |
| <input type="checkbox"/> Thyroid Disease: _____ | <input type="checkbox"/> Rheumatic Fever: _____ |
| <input type="checkbox"/> High Cholesterol: _____ | <input type="checkbox"/> HIV + / AIDS: _____ |
| <input type="checkbox"/> Angina / Heart Attack: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> High Blood Pressure: _____ | <input type="checkbox"/> Anxiety: _____ |
| <input type="checkbox"/> Heart Murmur: _____ | <input type="checkbox"/> Depression: _____ |
| <input type="checkbox"/> Other: _____ | |

Prior Colonoscopy? Y N When? _____ Any polyps found / # polyps _____

Prior Surgeries _____

Do you smoke tobacco? Y N Packs / cigarettes per day? _____
 Do you drink alcohol? Y N Current drinks per day: _____
 Illegal drug use in the past or present? Y N Counseling or psychiatric care? Y N

Family History: Has any blood relative had any of the following problems? (please check any that apply)

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Crohn's/UC | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack |

Family Member History

	Living	Deceased	Current Age / Age at Death	Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother / Sisters	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandparents (Maternal / Paternal)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do any of your children have health problems?	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	

(please explain)

Please check any of the conditions / symptoms listed below that you have had in the past 3-6 months.

General

- Unusual fatigue or weakness
- Chills / fevers >101
- Bleeding tendency
- Hot or cold intolerance
- Unintended weight loss

Lungs

- Persistent cough
- Coughing up blood, mucus or pus
- Shortness of breath
- Wheezing
- Difficulty breathing while lying down

Eyes

- Double / blurred vision
- Blind areas

Stomach / Digestive Tract

- Frequent indigestion / heartburn / GERD
- Nausea / vomiting
- Diarrhea / constipation
- Black stool
- Abdominal pain: Location _____

Ears

- Hearing loss
- Ear ache
- Ringing in ears

Colon / Rectum

- Blood in stool / rectal bleeding
- Recent change in bowel habits
- Anal / rectal pain
- Anal itching
- Anal masses / hemorrhoids
- Inability to control stool / incontinence

Throat / Mouth

- Sore mouth, tongue, lips
- Hoarseness
- Difficulty swallowing

Urinary Tract

- Pain or burning while urinating
- Urinating frequently at night
- Slow starting or stopping urine stream
- Discharge / bloody or dark urine
- Inability to control urine / incontinence

Heart

- Irregular / skipped beats
- Racing or flutter
- Pounding heart
- Chest pain
- Swollen feet / ankles

Mood

- Depression
- Irritability
- Anxiety
- Stress / Tension
- Anger

Nervous System

- Dizziness
- Blackouts
- Migraines
- Stroke
- Paralysis
- Seizures

Additional Comments

Bones / Joints / Muscle Problems

- Painful or stiff joints
- Muscle cramps / aching
- Back pain
- Arthritis