Custom Family Care
Ivan Pivovarov, MD

Date: _____

Medical History Form

Your answers on this form will help your health care provider understand your medical concerns and conditions better. If you can not remember specific details, please provide your best guess. **Thank You!**

Name: _____ Age: _____ D.O.B.: _____/_____/_____

Occupation: _____ Employer: _____

Marital Status: ___Married ___Single ___Widowed ___ Divorced Referred by: _____

What symptoms or problems made you come to the Doctor's office?_____

_____

Review of Symptoms: Please check (√) any current symptoms you have.

Constitutional
___ Recent fevers/sweats
___ Unexplained weight loss/gain
___ Unexplained fatigue/weakness

Eye
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficulty hearing/ringing in ears
___ Hay fever/allergies/congestion
___ Trouble swallowing

Cardiovascular
___ Chest pains/discomfort
___ Palpitations
___ Short of breath with exertion

Breast
___ Breast lump
___ Nipple discharge

Respiratory
___ Cough/wheeze
___ Coughing up blood

Gastrointestinal
___ Heartburn/reflux
___ Blood or change in bowel movement
___ Nausea/vomiting/diarrhea
___ Pain in abdomen

Genitourinary
___ Painful/bloody urination
___ Leaking urine
___ Nighttime urination
___ Discharge: penis or vagina
___ Unusual vaginal bleeding
___ Concern with sexual functions

Musculoskeletal
___ Muscle/joint pain
___ Recent back pain

Skin
___ Rash
___ New or change in mole

Neurological
___ Headaches
___ Memory loss
___ Fainting

Psychiatric
___ Anxiety/stress
___ Sleep problems

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Endocrine
___ Cold/heat intolerance
___ Increase thirst/appetite

Other (please specify)
_____

Current Medications: Prescriptions and over the counter medicines

Medication	Dose	Times Per day

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Allergies or reactions to medicines/foods/other agents:

Medication	Type of Reaction

Yes	No	**Please check (√) yes or no and list amount (if applicable)**
		Do you smoke or use any form of tobacco? Packs or amount per day_____
		Do you drink alcoholic beverages? Type and amount per day _____

Health Maintenance Screening Tests:	Date of Last	Abnormal?	
		Yes	No
Chest X-Ray			
Lipid (cholesterol)			
EKG			
TB Skin Test			
Eye Exam			
Pap Smear (if female)			
Mammogram			
Colonoscopy			
Prostate Exam (if male)			
Other (specify)			

Surgical History: List all surgeries with dates

Personal Medical History: Please check (√) if you have had any of the following medical conditions (with dates)

	Condition	Year		Condition	Year
	Heart murmur			Diabetes	
	Varicose veins			Thyroid problems	
	Blood clots			Kidney stones	
	Stroke			Arthritis	
	High blood pressure			Osteoporosis	
	High cholesterol			Seizures	
	Angina (chest pain)			Migraine headaches	
	Heart attack			Depression	
	Asthma/ COPD			Anemia	
	Emphysema			Sickle cell disease	
	TB			Blood disorders	
	Ulcers			Cancer	
	Hepatitis			Glaucoma	
	Colitis			Other	

Family History: Have your biological family (parents, brothers, sisters, grandparents, aunts and uncles) had any of the following conditions?

Yes	No	Condition	Relative	Yes	No	Condition	Relative
		TB				Anemia	
		Rheumatic Fever				Arthritis	
		Diabetes				Glaucoma	
		Thyroid Disease				Lung Disease	
		Cancer				Kidney Disease	
		Heart Disease				Mental Illness	
		High Blood Pressure				Other:	
		Stroke					
		Stomach Problems					
		Bleeding Problems					

Women's Pregnancy/GYN History: # pregnancies _____ # deliveries _____ # abortions _____
miscarriages _____ 1st day, most recent period: _____ Are your periods regular? _____
Age at start of periods: _____ Current birth control method? _____
Age at end of periods: _____

Immunizations: Please check (√) if you have had any of the following immunizations (with dates)

___ Hepatitis A
___ Hepatitis B
___ Tetanus (Td)
___ Tetanus & pertusis (Tdap)
___ Measles/Mumps/Rubella (MMR)
___ Varicella (chicken pox)
___ Pneumovax (pneumococcal)
___ Meningococcal
___ Human Papillomavirus (HPV)
___ Seasonal Flu
___ H1N1 Flu
___ Other