**MEDICAL HISTORY WORKSHEET** **Raleigh Medical Group**

**Name:** _____ _____ **DOB:** ___/___/___ **Chart #:** _____

**Personal Data:**

Marital status: **Make a selection

Occupation (if applicable): _____ Education: _____

Tobacco Product Use: (Select one)
☐ None
☐ Current Use
☐ Past Use
Type of product: _____
How much per day? _____ How long? _____

Daily caffeine consumption: ☐ Y ☐ N How much per day? _____

Alcohol use: ☐ Y ☐ N
How much per: day _____ week _____ month _____

Do you use any other types of drugs other than over-the-counter, supplements and/or prescription medications? ☐ Y ☐ N
If yes, what do you use and how often? _____
_____

Exercise Regimen: How often? _____ What type? _____

Do you wear your seat belt on a regular basis? ☐ Y ☐ N

**Medication allergies:** Please list any medication allergies and type of reaction:

| Name of Medication | Reaction |
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Do you have any other allergies? (i.e. foods, dyes, environmental, bee stings, etc)
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**Medications (Prescription/Over-the-Counter/Supplements)**

| Name of medication | Dosage | Daily directions |
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| Current Medical Problems | Date of Onset |
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| Past Medical Problems/Hospitalizations/Surgeries | Date |
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**Females: # of pregnancies**_____ **# of live births**_____ **Type of delivery:**_____

**Family Medical History:** Please list all relatives diagnosed with any of the following conditions including their age at onset (please note if deceased).

Heart disease:_____
Diabetes: _____
Cancer/Type: _____
Hypertension: _____
Mental Health/Depression: _____
Other: _____

**Screenings** (date of last):
Mammogram:_____
Pap Smear:_____
Colonoscopy:_____
Bone Density:_____
PSA:_____

**Immunizations** (date received):
Tetanus:_____
Pneumovax:_____
Influenza:_____
Hepatitis A/B:_____
PPD (TB Skin Test):_____
Zostavax:_____
Tdap:_____

**Do you have a living will?** ☐ Y ☐ N **Advanced Directive?** ☐ Y ☐ N

**Other specialists that you see on a regular basis:** (Name and specialty)

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