SHILOH FAMILY MEDICINE
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PAST MEDICAL HISTORY

PATIENT INFORMATION: ❑ PREVIOUSLY DR CLACK'S PATIENT

LAST NAME	FIRST	MIDDLE	DOB

WHAT ARE THE TOP 3 REASONS FOR YOUR VISIT TODAY?:

1

2

3

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT APPLY TO YOU:

General
☐ Fever
☐ Sweats

Cardiovascular
☐ Chest pain or pressure
☐ Ankle swelling
☐ Palpitations

Respiratory
☐ Cough
☐ Shortness of breath
☐ Wheezing
☐ Shortness of breath with exertion

Ear/Nose/Throat
☐ Ear pain
☐ Difficulty swallowing
☐ Loss of hearing

Eyes
☐ Blurred vision
☐ Changing vision

Mental Health
☐ Insomnia
☐ Depression
☐ Anxiety
☐ Suicidal thoughts

Skin
☐ Rash
☐ Changing mole
☐ Itching
☐ Slow healing wounds

Genitourinary
☐ Urinary frequency
☐ Burning with urination
☐ Blood in urine
☐ Problems with urinating
☐ Awaken at night to urinate
☐ Problems with sex
☐ Exposure to STD

Endocrine System
☐ Excessive urination
☐ Excessive thirst
☐ Fatigue
☐ Heat intolerance
☐ Cold intolerance

Neurologic System
☐ Numbness
☐ Tingling
☐ Headaches
☐ Weakness

Allergy
☐ Seasonal
☐ Itchy eyes
☐ Runny nose
☐ Nasal congestion
☐ Postnasal drip

Hematologic System
☐ Easy bruising
☐ Easy bleeding

GI system
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Abdominal pain
☐ Diarrhea
☐ Blood in stool

Nutrition
☐ On a special diet
☐ Weight gain/loss greater than 10lbs

Musculoskeletal
☐ Joint swelling
☐ Joint pains
☐ Muscle pains

Daily Living
☐ Violence in your home
☐ Changes in functional ability
☐ Changes in eating habits
☐ Changes in sleeping habits

PAST MEDICAL HISTORY:

☐ High blood pressure
☐ High cholesterol
☐ Liver disease
☐ Diabetes ("sugar")
☐ Thyroid problems
☐ Kidney Disease
☐ Heart Attack: Age_____
☐ Heart Failure
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Stroke
☐ Seizures/Epilepsy
☐ Stomach Problems
☐ Intestinal Problems
☐ Reflux Disease
☐ Arthritis
☐ Osteoporosis
☐ Anemia
☐ Abnormal PAP
☐ Bipolar Disorder
☐ Depression
☐ Anxiety
☐ Low Back Pain
☐ Migraine/headache
☐ Cancer Type: _____
☐ Other:

List all current medications (Dose & Frequency):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10.

List all drug allergies (Type of reaction):
1. _____
2. _____
3. _____

List all specialists:
1. _____
2. _____
3. _____
4. _____
5. _____

HAVE YOU EVER PARTICIPATED IN OSTEOPATHIC MANIPULATION TREATMENT (OMT)? ❑ YES ❑ NO DID IT HELP? ❑ YES ❑ NO

RECENT HOSPITALIZATIONS OR SURGERY: ❑ **NONE**

PREVENTATIVE CARE:

What year were these shots or tests given?
Tetanus Booster: _____ Flu Shot: _____
Pneumonia Vaccine: _____ Hepatitis Vaccine: _____
Shingles Vaccine (Age>60): COVID:

Bone Density: _____
Colonoscopy: ❑ NORMAL ❑ ABNORMAL _____
What do you use for birth control? ❑ Birth Control Pills ❑ Condoms ❑ IUD ❑ Vasectomy ❑ Ring/Diaphragm ❑ None

MALES ONLY:

Do you have any problems with erections? ❑ Yes ❑ No

FEMALES ONLY:

Age of first period: _____ Last menstrual period: _____ Regular? ❑ Yes ❑ No
Number of pregnancies: _____ Number of births: _____ Hysterectomy: ❑ Yes ❑ No Age of menopause: _____
When was your last mammogram? _____ ❑ Normal ❑ Abnormal: _____
When was your last PAP smear? ❑ Normal ❑ Abnormal:

SOCIAL HABITS:

Have you ever used tobacco products? ❑ Yes ❑ No
What kind? _____
How much? _____ How many years? _____
Ever tried to quit? ❑ Yes ❑ No Date quit _____
Do you use drugs? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No
How many drinks per week? _____
Have you ever felt you need to cut down? ❑ Yes ❑ No
Have you ever felt guilty about drinking? ❑ Yes ❑ No

Do you exercise regularly? What form? _____
Briefly describe your diet: _____
Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed
Are you sexually active with: ❑ one partner ❑ multiple partners ❑ with women ❑ with men ❑ none
Any history of sexually transmitted disease? (Type/year) _____
Who do you live with? _____ Do you feel safe at home? ❑ Yes ❑ No
What are the ages of your children? _____
Occupation _____ Work Ph # _____
Your Pharmacy: _____ Address: _____

FAMILY HISTORY:

	Mother	Father	Grandparents		Brother	Sister	Other	Details
			Maternal	Parental				
High Blood Pressure								
High Cholesterol								
Age of Heart Attack								
Diabetes								
Stroke								
Cancer (Type)								
Osteoporosis								
Mental Illness								