MobileMed
Onsite Insight

MEDICAL & FAMILY HISTORY FORM

TODAY'S DATE:_____/_____/_____

NAME:_____**DATE OF BIRTH**:_____/_____/_____

Chief Complaint:_____

Medications - Please list all of your current prescription and non-prescription medications. (ex: vitamins and supplements)

Medication Name:	**Dosage:**
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: □ None □ Penicillin □ Sulfa □ Aspirin □ Iodine □ Latex □ Others:_____

Description of allergic reaction:_____

Past Medical History

□ Anemia	□ Colon polyps	□ Gastritis	□ Irritable bowel syndrome	□ Prostate enlargement
□ Arthritis	□ Congestive Heart Failure	□ GERD (Reflux)	□ Kidney disease/failure	□ Psoriasis
□ Asthma	□ Constipation	□ GI Bleeding	□ Liver Disease	□ Rheumatic fever
□ Atrial Fibrillation	□ COPD	□ Heart attack	□ Neurologic Disorders	□ Sciatica
□ Barrett's Esophagus	□ Coronary Artery Disease	□ Heart murmur	□ Osteoporosis	□ Seizures
□ Bleeding disorder	□ Crohn's disease	□ Hepatitis	□ Ovarian cyst	□ Sleep apnea
□ Blood transfusion	□ Depression	□ Hiatal hernia	□ Pancreatitis	□ Stroke
□ Cancer	□ Diabetes	□ High blood pressure	□ Parkinson's disease	□ TB (Tuberculosis)
□ Chronic anxiety	□ Diverticulosis	□ High cholesterol	□ Peptic ulcer	□ Thyroid disorders
□ Chronic sinusitis	□ Fatty liver	□ HIV or AIDS	□ Phlebitis	□ Ulcerative colitis
□ Cirrhosis	□ Gallbladder Disease	□ Irregular heart beat	□ Pneumonia	□ Valvular Heart Disease
□ Colon cancer				

Previous Hospitalizations

Reason:	**Date:**
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries/Procedures

□ Appendectomy	Date:_____	□ Heart bypass	Date:_____	□ Radiation Therapy	Date:_____
□ Barium Enema	Date:_____	□ Heart valve Replacement	Date:_____	□ Sigmoidoscopy	Date:_____
□ Breast Surgery	Date:_____	□ Hemorrhoid surgery	Date:_____	□ Small Bowel Resection	Date:_____
□ Capsule Endoscopy	Date:_____	□ Hiatal hernia repair	Date:_____	□ Stomach Surgery	Date:_____
□ Cholecystectomy	Date:_____	□ Hysterectomy	Date:_____	□ Thyroid Surgery	Date:_____
□ Colon surgery	Date:_____	□ Joint replacement	Date:_____	□ Tonsillectomy	Date:_____
□ Colonoscopy	Date:_____	□ Kidney Surgery	Date:_____	□ Tubal ligation	Date:_____
□ Colostomy	Date:_____	□ Liver biopsy	Date:_____	□ Ulcer Surgery	Date:_____
□ C-section	Date:_____	□ MRI	Date:_____	□ Ultrasound	Date:_____
□ CT Scan	Date:_____	□ Obesity surgery	Date:_____	□ Upper GI Series X-ray	Date:_____
□ EGD	Date:_____	□ Ovarian Surgery	Date:_____	□ Uterine Surgery	Date:_____
□ ERCP	Date:_____	□ Pacemaker Placement	Date:_____	□ None	Date:_____
□ Gallbladder Surgery	Date:_____	□ Prostate (TURP)	Date:_____	□ Other:_____	

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Healthy/Alive	□ Father	□ Mother	□ Brothers	□ Sisters
Deceased	□ Father	□ Mother	□ Brothers	□ Sisters
Colon polyps	□ Father	□ Mother	□ Brothers	□ Sisters
Colon cancer	□ Father	□ Mother	□ Brothers	□ Sisters
Gastriculcer disease	□ Father	□ Mother	□ Brothers	□ Sisters
Liver disease	□ Father	□ Mother	□ Brothers	□ Sisters
Pancreas disease	□ Father	□ Mother	□ Brothers	□ Sisters
Crohn's disease	□ Father	□ Mother	□ Brothers	□ Sisters
Ulcerative colitis	□ Father	□ Mother	□ Brothers	□ Sisters
Stomach cancer	□ Father	□ Mother	□ Brothers	□ Sisters
Diabetes mellitus	□ Father	□ Mother	□ Brothers	□ Sisters
Heart attack	□ Father	□ Mother	□ Brothers	□ Sisters
Breast cancer	□ Father	□ Mother	□ Brothers	□ Sisters
Other cancer	□ Father	□ Mother	□ Brothers	□ Sisters

Social History

Marital status: □ single □ married □ divorced □ widowed □ separated □ domestic partner

Occupation:_____□ unemployed □ retired □ student

Smoking history: □ never □ yes;_____packs per day for _____years; Quit (how long)_____

Alcohol use: □ no □ yes; amount per day:_____for_____years

Drug use: □ no □ yes; specify drugs and amounts: _____

Exercise habits: □ no □ yes; how much and how often: _____

Do you have any tattoos? □ no □ yes **Do you have any piercings?** □ no □ yes

Recent travel outside US: □ no □ yes; where:_____

Caffeine use: □ no □ yes; details:_____

Date of last Pneumovax: _____**Date of last flu shot:**_____

Review of Systems—check all that apply at the present time

General-
□ chills
□ fever
□ loss of appetite
□ night sweats
□ weight gain
□ weight loss
□ feeling tired or poorly

Eyes-
□ worsening of vision
□ blurred vision
□ vision distortion
□ eye pain

Otolaryngeal Systems-
□ earache
□ nasal discharge
□ mouth sores
□ bleeding gums
□ hoarseness
□ throat pain
□ facial pain
□ sinus pain

Cardiovascular-
□ chest pain/discomfort
□ fast heart rate
□ swelling of legs
□ varicose veins

Pulmonary-
□ cough
□ wheezing
□ shortness of breath

Gastrointestinal-
□ abdominal swelling/pain
□ belching
□ black stools
□ red blood in bowel movement
□ change in bowel movement frequency
□ constipation
□ diarrhea
□ difficulty swallowing
□ fatty food intolerance
□ full after eating small meals
□ gas/bloating
□ heartburn
□ hemorrhoids
□ yellow skin or eyes
□ nausea
□ pain with swallowing
□ decrease in appetite
□ rectal pain/bleed
□ regurgitation of food
□ incontinence of stool
□ vomiting
□ vomiting blood

Musculoskeletal-
□ joint pain
□ joint stiffness
□ swollen joints
□ low back pain
□ muscle pain

Skin Symptoms-
□ Pruritis (itching)
□ skin lesions
□ rashes

Neurologic-
□ numbness or tingling
□ dizziness/lightheadedness
□ vertigo
□ headaches
□ weakness in arms or legs
□ blurred vision
□ memory lapses or loss

Psychiatric-
□ anxiety
□ depression
□ panic attacks
□ loss of sleep

Endocrine-
□ heat or cold intolerance
□ excessive thirst or urination
□ hot flashes

Hematologic/Lymphatic-
□ easy bruising tendency
□ swollen glands
□ nosebleeds

Urinary-
□ pain or difficulty with urination
□ frequent urination
□ blood in urine
□ incontinence of urine

Genitoreproductive-Female
□ vaginal discharge
□ heavy periods
date of last period:_____

Genitoreproductive-Male
□ discharge from penis
□ testicular pain
□ testicular lump