

**Jon Bishop, MD Patient Medical History Form**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Visit Date:** \_\_\_\_\_

**Pharmacy you use:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Reason for today's visit: (please list anything you'd like to discuss with Dr. Bishop):**

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**Current Medication:**

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**Past Medical History: (Please check all that you have had):**

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|--|---|---|---|--|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Lung Problems        | <input type="checkbox"/> Hernia         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> AICD (Defibrillator) | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Bleeding Tendencies  | <input type="checkbox"/> Broken Bones        |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> HIV                     | <input type="checkbox"/> Hepatitis B          | <input type="checkbox"/> Hepatitis C    |   |  |

**Please list any medications you are allergic to and any other allergies we should know about:**

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**Surgical History (please check all that you have had):**

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|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> Colonoscopy  | <input type="checkbox"/> EGD(Upper Endoscopy) | <input type="checkbox"/> Ulcer Surgery  | <input type="checkbox"/> Colon Surgery           | <input type="checkbox"/> Cholecystectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hemorrhoidectomy     | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Hysterectomy    |

**Surgical History Continued:**

- Ovaries Removed       Breast Cancer Surgery       Prostate Surgery       Back Surgery       Hip Surgery  
 Knee Surgery       Weight Loss Surgery

**Family History (only check those that apply):**

**Mother:**

- Arthritis       Heart Attack       Peripheral Vascular Disease       Hypertension       Drug Abuse  
 High Cholesterol       Diabetes Mellitus       Stroke       Cancer       Alcohol Abuse

**Father:**

- Arthritis       Heart Attack       Peripheral Vascular Disease       Hypertension       Drug Abuse  
 High Cholesterol       Diabetes Mellitus       Stroke       Cancer       Alcohol Abuse

**Siblings:**

- Arthritis       Heart Attack       Peripheral Vascular Disease       Hypertension       Drug Abuse  
 High Cholesterol       Diabetes Mellitus       Stroke       Cancer       Alcohol Abuse

**Grandparents:**

- Arthritis       Heart Attack       Peripheral Vascular Disease       Hypertension       Drug Abuse  
 High Cholesterol       Diabetes Mellitus       Stroke       Cancer       Alcohol Abuse

**Social History:**

**Marital status:**     Married       Single       Divorced       Widowed       Life Partner

**Occupation:**     Full Time       Part Time       Retired       Homemaker       Student  
 Unemployed     Disabled

**Who lives with you:**     Spouse       Children       Partner       Mother       Father  
 No one       Other

**Exercise:**       Never       Daily       1-2x per week       3-4x per week

**Caffeine Use (includes caffeinated soda):**     None       Daily       Occasionally

**If used daily indicate amount:**     1 cup/drink per day       2-3cups/drinks per day       4+ cups/drinks per day

**Tobacco Use:**     Yes       No       Trying to Quit       Previous Smoker

**Type:**     Cigarettes       Cigars       Smokeless Tobacco       Other

**Social History Continued:**

**Cigarette daily use:**       ½ pack/day       1 pack/day       2 packs/day       more than 2 packs/day

**Alcohol use:**       Never       Daily       Social Drinker       Trying to quit       Recovering Alcoholic

**Drug Abuse:**       Never       Daily       Occasionally       Trying to quit       Recovering addict

**Please mark YES or NO for any symptoms you have had within the last two weeks**

**Ears:**

Recurring ear infections:       Yes  No

Hearing Loss:       Yes  No

**Eyes:**

Visual Problems:       Yes  No

Dry Eyes:       Yes  No

**Abdomen:**

Abdominal pain:       Yes  No

Heartburn:       Yes  No

Constipation:       Yes  No

Diarrhea:       Yes  No

Blood in stool:       Yes  No

**Nose:**

Difficulty Breathing through nose:       Yes  No

Allergies:       Yes  No

**Extremities:**

Joint pain:       Yes  No

Unusual pain:       Yes  No

**Cardiovascular:**

Chest Pain:       Yes  No

Irregular heart beat:       Yes  No

**Lungs:**

Pneumonia       Yes  No

Cough:       Yes  No

Wheezing:       Yes  No

**Breast:**

Lumps:       Yes  No

Breast pain:       Yes  No

Discharge:       Yes  No

**Neurological:**

Headaches:       Yes  No

Weakness/Numbness:       Yes  No

**GU-Gyn:**

Dizziness:       Yes  No

Urinary Problems       Yes  No

Prostate Problems:       Yes  No