THOMASON MEDICAL CLINIC

PAST MEDICAL HISTORY

Please check which of the following you have been diagnosed to have. Mark the date of the diagnosis in the column next to the diagnosis.

DIAGNOSIS	DATE		DIAGNOSIS	DATE
☐ Headaches			☐ Gastrointestinal Bleeding	
☐ Stroke			☐ Hepatitis (A,B,C)	
☐ Seizures			☐ HIV/AIDS	
☐ Pneumonia			☐ Chronic Wounds	
☐ Diabetes (Type 1 or 2)			☐ Cancer (Type)	
☐ Hypothyroidism			☐ Urinary Tract Infections	
☐ Glaucoma			☐ Inability to Control Urine	
☐ Macular Degeneration			☐ Kidney Stones	
☐ Hearing Loss			☐ COPD	
☐ High Blood Pressure			☐ Asthma	
☐ High Cholesterol			☐ Depression	
Blood Clots			☐ Bipolar Disorder	
☐ Pulm Emboli (lung clots)			☐ Anxiety	
☐ DVT (leg clots)			☐ Fibromyalgia	
Heart Disease			☐ Arthritis	
☐ Coronary Disease			☐ Gout	
☐ MI/Heart Attack			☐ Osteoporosis	
☐ Congestive Heart Failure			☐ Prostate Disease	
☐ Atrial Fibrillation			☐ Attention Deficit Disorder	
☐ Angina			☐ Other: _____	
☐ Valve Disorder			☐ Other: _____	
☐ Seasonal Allergies			☐ Other: _____	
☐ Erectile Dysfunction			☐ Other: _____	

SOCIAL HISTORY

	CIRCLE YES OR NO	HOW MANY PER DAY	WHAT TYPE	START DATE
Alcohol	YES OR NO			
Tobacco	YES OR NO			
Other Recreational Drugs	YES OR NO			

Check the following that apply to you.

Work:	☐ Employed	☐ Unemployed	☐ Retired	☐ Disabled
Marital Status:	☐ Married	☐ Single	☐ Divorced	☐ Partner

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FAMILY HISTORY

Please check your family members (deceased or living) that have the following medical issues in their history.

Alcoholism	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Asthma	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Breast Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Colon Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Depression	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Elevated Lipids	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Heart Attack	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other:
High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Lung Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Migraines	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Osteoporosis	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Ovarian Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Prostate Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Skin Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Thyroid Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Uterine Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Other Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Other Diagnosis	☐ Father	☐ Mother	☐ Sibling	☐ Other:
Other Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Other:

ALLERGIES

List all allergies (drug and environmental) that you have and your reaction.

Allergy	Reaction

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IMMUNIZATIONS

Circle YES or NO to indicate which immunizations you have received. List the date and/or year you received each immunization if you can recall.

Immunization	YES OR NO	Date
Td- Adult Tetanus Toxoid	YES OR NO	
Influenza	YES OR NO	
Pneumovax (Pneumonia)	YES OR NO	
Prevnar (Pneumonia)	YES OR NO	
Shingles (Zostavax/Shingrix)	YES OR NO	
MMR (If born after 1957)	YES OR NO	
Varicella (Chicken Pox)	YES OR NO	
Covid-19 Vaccine #1	YES OR NO	
Covid-19 Vaccine #2	YES OR NO	
Covid-19 Vaccine (Booster)	YES OR NO	

CURRENT MEDICATIONS

Please list all of the medications you are currently taking below.

Name of Medication	Dosage	Direction	Reason for Taking

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PREGNANCY AND BIRTH

Date of Last Menstrual Period: _____ Age of First Period: _____
Number of Days in Flow: _____ Number of Days between Cycles: _____
Are you in Menopausal?: _____ Age of Onset of Menopause: _____
Number of Pregnancies: _____ Number of Live Births: _____ Number of Miscarriages: _____
Number of Living Children: _____ Number of Abortions: _____

PAST SURGICAL HISTORY

Please check all the surgeries that you have had. Indicate the date as well.

Type of Surgery	Date		Type of Surgery	Date
☐ None			☐ Gall Bladder	
☐ Adenoidectomy			☐ Heart Valve	
☐ Appendectomy			☐ Hemorrhoidectomy	
☐ Bariatric Surgery			☐ Hernia	
☐ Bladder Surgery			☐ Hysterectomy	
☐ Bowel/Stomach Resection			☐ LASIK	
☐ Cardiac Stents			☐ Orthopedic/Joints	
☐ Cataracts			☐ Pacemaker	
☐ C-Section			☐ Prostate Surgery/Resection	
☐ Colonoscopy			☐ Spinal Surgery	
☐ Coronary Bypass			☐ Thyroidectomy	
☐ Dental/Oral			☐ Tonsillectomy	
☐ Ear Tubes			☐ Tubal Ligation	
☐ Endoscopy			☐ Other: _____	

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HEALTH MAINTENANCE

Please list the dates for the last exam that you had for the following.

Type of Exam	Date of Last Exam
For Women: Mammogram	
For Women: Pap Smear	
Bone Density	
Colonoscopy	
Eye Exam (Diabetic Patients)	
For Men: PSA (Prostate Cancer Screening) Level	
Dental Exam	

Please provide a list of any other doctors/providers you see or have seen in the past 3 years.

Name (First and Last)	Specialty	Phone Number

What is your preferred local Pharmacy? _____
Location: _____ Phone Number: _____

What is your preferred mail order Pharmacy? _____
Phone Number: _____