WALNUT CREEK MEDICAL GROUP
MEDICAL HISTORY

Name__________________________________________ Nickname______________________ Date____________ Age______ DOB_____________
What is your primary language: __________________________ What is your ethnicity: ___________________________________________________
What health concerns do you have for today's visits?
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**Past Medical History**
If you have ever been hospitalized, please specify dates and reasons
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**Past Surgeries**
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**Medications**
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**Drug Allergies** (include reaction): ____________________________________________________________________________

**Food Allergies**: ____________________________________________________________________________________________

Name any other physician(s) you are currently seeing: ________________________________________________________________
Are you currently seeing a therapist? (name):______________________________________________________________________

**Health care maintenance**: Normal?

Date of last physical exam _____________ _____________
Date of last bloodwork _____________ _____________
Date of last pap smear _____________ _____________
Date of last mammogram _____________ _____________
Date of last colonoscopy _____________ _____________ Polyps? __________
Date of last DEXA _____________ _____________
Date of last Tetanus shot _____________
Do you exercise on a regular basis? _____Yes _____No If so, what type __________, frequency _________ duration ______

**Social History**
Birthplace: _________________________________ Hand dominance _____right _____left _____ambidextrous
Education: ________________________ Degree obtained: ________________________
Employment: _________________________________________ Occupation: ______________________________________________________________
Military Experience: _____yes _____no Occupational hazards: _____________________________________________________________
Marital Status: ____single _____married _____separated _____divorced _____widowed Sexual Orientation: _____________________________
Children (name/gender/age): ______________________________________________________________________________
Who currently lives at home with you? ________________________________________
Smoking (type/amount): ____________________________________________________ For how many years?: _____________________________
Alcohol (type/amount): ______________________________ Do you have a history of alcohol abuse? ____Yes ____No
Caffeine: ____Yes ____No Type: ________ How Much: ____ Do you use recreational drugs?: ____Yes ____No Do you wear a seat belt? Yes/No
Are there animals in the home (type)?: ____________________________________ Do you clean up after the animal(s)? ____Yes ____No
Do you have a religious affiliation?(list): __________________________________________

**Home Environment/Safety**
Smoke detectors in home? ____Yes ____No Carbon monoxide detectors? ____Yes ____No
Radon in home? ____Yes ____No Home heating: ___Gas ____Electric ____wood ____solar ____oil ____coal
Firearms at home? ____Yes ____No Do you wear a seat belt? ____Yes ____No

**Advanced Directives**
Do you have an advanced health care directive? ____Yes ____No