DOYLESTOWN MEDICAL ASSOCIATES, P.C.

Medical History

Date: _____

Name: (Print)_____ Date of Birth: _____

Race: _____ Preferred Language: _____

Ethnicity: ❑Non-Hispanic ❑Hispanic

Marital Status: ❑Single ❑Married ❑Divorced ❑ Widowed

Pharmacy: Local_____ Mail Order: _____

Do you feel you are safe from violence in your home and workplace? ❑ Yes ❑ No

Please circle any problems you are CURRENTLY having from the list below

Constitutional - chills, fever
Cardiovascular – Chest pain, shortness of breath, irregular heartbeat, palpitations
Endocrine – cold intolerance, heat intolerance, increased thirst, weight loss, weight gain
Ears/Throat – ear infection, sore throat
Eyes – double vision, eye pain
GI – abdominal pain, constipation, decreased appetite, diarrhea, nausea, vomiting
Urinary – burning when you urinate, frequent urination, blood in your urine, leaking urine
Hematologic – easy bleeding, easy bruising
Skin – itching skin, rash
Musculoskeletal – back pain, joint pain, muscle pain, weakness
Neurologic – headache, tremors, visual changes, pain , weakness
Psychological – anxiety, depression
Respiratory – chronic cough, shortness of breath, wheezing, asthma
Reproductive – female: vaginal itch, vaginal discharge male: burning, discharge

Tobacco use – none / current user / past user Type: _____ Per day: _____ How long: _____

Daily caffeine – ❑yes ❑no Per day: _____

Alcohol Use – ❑yes ❑no Amount: _____ Frequency: _____

Current exercise – How often: _____ What type: _____ Frequency: _____

Chronic Medical Problems:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Past Medical / Surgical History:

1. _____ 2. _____ 3. _____

PLEASE TURN PAGE OVER TO COMPLETE SIDE 2

Family Medical History:

Father: _____

Mother: _____

Siblings: _____

Health Screening:

Mammogram: Date: _____ Result: _____ Testing Facility: _____

Colonoscopy: Date: _____ Result: _____ Testing Facility: _____

Eye Exam: Date: _____ Result: _____ Ophthalmologist: _____

Bone Density: Date: _____ Result: _____

Pap: Date: _____ Result: _____ Gynecologist: _____

If you have had a hysterectomy, please provide the date: _____

Diabetic yearly insurance required screenings:

Hemoglobin A1c blood test: Date: _____ Result: _____

Microalbumin urine test: Date: _____ Result: _____

Diabetic eye exam: Date: _____ Result: _____

Do you take a statin medication for cholesterol? (Atorvastatin, Rosuvastatin and Pravastatin are examples). If so, please list the medication here _____

Please list other physicians you regularly see:

Cardiology: _____ Dermatologist:_____

Endocrinologist: _____ Gastroenterologist: _____

Gynecologist: _____ Orthopedist: _____

Ophthalmologist: _____ Rheumatologist: _____

Urologist: _____ Other: _____

Do you have a Living Will? ❑Yes ❑No
Do you have an Advance Directive? ❑Yes ❑No
Would you like information about Living Wills and Advance Directives? ❑ Yes ❑No

Please provide your email address for additional non-urgent communications form our physicians.

Email: _____