Georgia Osteopathic Care Center

PCOM Georgia

Medical History

Please print the following information: Today's Date _____

Name: _____ Date of Birth: _____

Occupation: _____ Education: _____

Medications you are currently taking: _____

_____

Allergies (including medication) _____

Reason for today's visit: _____

_____

Please describe your diet:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____

Please describe any and all regular exercise: _____

_____

Hospitalizations:

Please indicate Year, Procedure/Illness, Hospital, City/State

1. _____
2. _____
3. _____
4. _____

Have you had any recent imaging (X-ray, CT Scan, MRI)? Yes ☐ No ☐

If you answered yes, please list the approximate date, location, type of imaging, and area of the body:

_____

_____

_____

Please list any history of trauma (motor vehicle accidents, sports injuries, concussions, etc.)

_____

_____

_____

*Continued on other side.

Personal Medical History

X = current condition, Circle = in the past/resolved

- ☐ Failing Vision
- ☐ Double or blurred vision
- ☐ Eye Pain
- ☐ Eye Infections
- ☐ Decreased Hearing
- ☐ Ringing / Buzzing in ears
- ☐ Ear Infections
- ☐ Allergies / Hay fever
- ☐ Sinus Trouble
- ☐ Nose Bleeds
- ☐ Frequent Sore Throats
- ☐ Prolonged Hoarseness
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Alcoholism
- ☐ High Blood Pressure
- ☐ Shortness of Breath on Exertion
- ☐ Shortness of Breath Lying Flat
- ☐ Chest Pain
- ☐ Heart Murmurs
- ☐ Palpitations
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain when walking
- ☐ Varicose Veins / Phlebitis
- ☐ Recent loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Persistent Nausea / Vomiting
- ☐ Ulcers
- ☐ Chronic Abdominal Pain
- ☐ Recent Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or Tarry Stool
- ☐ Red Blood in stools
- ☐ Hemorrhoids
- ☐ Diverticulitis
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Hernia
- ☐ Bladder Infections
- ☐ Kidney Infections
- ☐ Pain on Urination
- ☐ Poor Control of Urination
- ☐ Decreased Force of Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ STD
- ☐ Chronic Fatigue
- ☐ Recent Weight loss
- ☐ Excessive Weight Gain
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Cancer: _____ _____
- ☐ Diabetes
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Muscle Weakness
- ☐ Numbness / Tingling sensation
- ☐ Frequent Headaches
- ☐ Arthritis
- ☐ Gout
- ☐ Cold or Numb Feet
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Difficulty Sleeping
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness
- ☐ Phobias
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Chicken Pox
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Recreational Drug Use
- ☐ Alcohol: _____
- ☐ Cigarettes _____ Packs per day
- ☐ Coffee/Tea _____Cups per day
- ☐ # Pregnancies: _____
- ☐ # Live Births: _____
- ☐ # Miscarriages: _____
- ☐ Method of Birth Control_____
- ☐ Age of Onset of Menses: _____
- ☐ Irregular Period
- ☐ Light Flow
- ☐ Medium Flow
- ☐ Heavy Flow
- ☐ Length of Cycle _____
- ☐ Pain / Bleeding with Intercourse
- ☐ PMS: (Medium/Severe)
- ☐ Other: _____ _____

Family Medical History

*Place an **X** next to any condition that has been suffered by a blood relative and indicate which relative*.

- ☐ Allergies
- ☐ Arthritis
- ☐ Diabetes
- ☐ Genetic Disease: _____
- ☐ Stroke
- ☐ Kidney / Bladder problems
- ☐ Blood Clotting Disease
- ☐ Asthma
- ☐ Cancer: _____ _____
- ☐ Epilepsy
- ☐ Gout
- ☐ Ulcers
- ☐ Mental Illness
- ☐ High Blood Pressure
- ☐ Alcoholism
- ☐ Glaucoma
- ☐ Headaches
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Anemia
- ☐ Other: _____ _____ _____

Patient Signature: _____ ***Date:*** _____