O&O Alpan, LLC

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Date: _____

Patient Medical History Form

Patient Name: _____ Date of Birth:_____ Age:_____

Name you prefer to be called: _____

Primary Care MD:_____ Referring MD:_____

Main Reason for Today's Visit:

Medical History:

Diagnosis	Date Diagnosed	Care Provider	Medications/Therapies for this diagnosis/prescriber

Surgical History:

Date	Surgery	Provider/Hospital

Hospitalizations (not including surgeries listed above)

Date	Reason	Provider/Hospital

Other Medications (please include herbal supplements, vitamins, and over-the counter medications)

Current Pharmacy Name/Location/Phone Number:

Allergies/Reactions (including medications, foods, pollens, latex, venom, and other products)

Medication/Product/Food Reaction

Family History

Mother: Living ☐ Yes ☐ No If yes, Age ____ If no, cause of death and age_____

Father: Living ☐ Yes ☐ No If yes, Age ____ If no, cause of death and age_____

Brother/Sister: Living ☐ Yes ☐No If yes, Age ____ If no, cause of death and age_____

Brother/Sister: Living ☐ Yes ☐No If yes, Age ___ If no, cause of death and age_____

Brother/Sister: Living ☐Yes ☐ No If yes, Age ___ If no, cause of death and age_____

Personal/Family History

☐ None/unknown

Have you or any close members of your family (not listed above) including grandparents, aunts, and/or uncles had any of the following medical conditions?

	Self	Family	Relationship	Age Diagnosed
Recurrent Infections	□	□	_____	_____
Immune Deficiencies	□	□	_____	_____
Allergies	□	□	_____	_____
Asthma	□	□	_____	_____
Eczema/atopic dermatitis	□	□	_____	_____
Other skin disease (eg. Psoriasis)	□	□	_____	_____
Thyroid Disease	□	□	_____	_____
Reflux/heartburn	□	□	_____	_____
Bowel Disease (eg. Colitis)	□	□	_____	_____
Bleeding/Clotting Problems	□	□	_____	_____
Leukemia/lymphoma	□	□	_____	_____
Other Cancers	□	□	_____	_____
Lupus	□	□	_____	_____
High blood pressure	□	□	_____	_____
Heart disease/heart attack	□	□	_____	_____
Stroke	□	□	_____	_____
Anxiety/Depression	□	□	_____	_____
Osteoporosis	□	□	_____	_____

Current Review of Systems (please circle) if you are NOW or RECENTLY have experienced any of the following:

General: Unexplained weight loss/gain Fatigue Night Sweats Fevers Hair Loss

HEENT: Eye Redness Vision change (blurred/double) Ear Pain Hearing Loss Eye/ear drainage Runny Nose Nasal Congestion Nose/Mouth Ulcers Sore Throat Thrush Bleeding Gums

Cardiac: Chest Pain Palpitations Swelling/Edema (location): _____

Respiratory: Wheezing Cough Shortness of Breath Sputum Production

GI: Constipation Diarrhea Abdominal Pain Nausea Black Stool Blood in Stool/On Tissue

GU: Frequent Urination Painful Urination Change in Urine Color Frequent Urine Infections

Musculoskeletal: Joint Pain Joint Redness Joint Swelling Muscle Pain Bone Pain Weakness

Skin: Rash Hives Swelling (location:_____) Dry Skin Poor Wound Healing Warts

Neurologic: Headaches Weakness Numbness/Tingling Seizures

Psych: Anxiety Depression Insomnia Memory Loss

Endocrine: Excessive Thirst Excess Urination Hair Loss Hair Growth Cold/Heat Intolerant

Other: Bruising Nosebleeds Swollen Glands/Nodes Neck Stiffness Dental Problems