MBODY HEALTHCARE

Patient History

Name: _____

Preferred Name: _____DOB: _____

Address: _____

Phone 1: _____Phone 2: _____

Email: _____

Insurance: _____Phone: _____

Group#: _____Member ID: _____

We do not bill insurance but may provide information to laboratory, radiology, consultation providers

Emergency Contact: _____Relation: _____Phone: _____

Medications:

NAME	DOSE	FREQUENCY

Additional medications listed on back: [ ]

Preferred Pharmacy (Name/location): _____

Allergies: _____

Medical History: check if positive, write in additional

CARDIOVASCULAR		PULMONARY		GASTROINTESTINAL	
	Atrial fibrillation		Asthma		Acid reflux
	Heart disease / CAD		Chronic oxygen use		Barrett's esophagitis
	Heart valve disease		COPD / Emphysema		Cirrhosis
	High blood pressure		Recurrent pneumonia		Constipation
	High cholesterol		Sleep apnea		Crohns / Ulcerative Colitis
	Peripheral vascular disease				Diarrhea
					Hepatitis
		HEENT			Irritable bowel syndrome
			Allergies		
GENITOURINARY			Cataracts		
	Chronic kidney disease		Glaucoma		
	Erectile dysfunction		Hearing loss	MUSCULOSKELETAL	
	Kidney stones		Sinus disease		Chronic back pain
	Prostate enlargement		Vision loss		Fibromyalgia
	Recurrent UTIs				Gout
	Urinary incontinence				Osteoarthritis
					Rheumatoid arthritis
		HEMATOLOGY			
			Bleeding disorder		
SKIN			Chronic anemia		
	Eczema / atopic dermatitis		DVT history	ENDOCRINE	
	Psoriasis		Sickle cell		Diabetes, no insulin use
					Diabetes, with insulin use
					Pancreatitis
					Thyroid disease
ONCOLOGY		PSYCHIATRIC			
	Blood cancer		Alcohol abuse		
	Breast cancer		Anxiety		
	Cervical or uterine cancer		Bipolar	NEUROLOGIC	
	Colon cancer		Dementia		Chronic headaches
	Liver cancer		Depression		Migraines
	Lung cancer		Schizoaffective disorder		Neuropathy
	Prostate cancer				Parkinson's
	Skin cancer				Seizures

Surgical History: check if positive, circle site, write in additional

	SURGERY	YEAR
	Appendix	
	Cataract: both right left	
	Colonoscopy	
	EGD (upper endoscopy)	
	Gallbladder	
	Hernia repair: abdominal inguinal right left	
	Hysterectomy	
	Mastectomy / Lumpectomy: both right left	
	Prostate	

Tobacco Use: Type:_____ Packs/day:_____ # of Years:_____

Alcohol Use: [ ] None [ ] Occasional [ ] Frequent [ ] Daily

Family History: Mother: _____
Father: _____
Brother: _____
Sister: _____

Health Maintenance: check if done

	SCREENING EXAMS	RESULTS	YEAR
	AAA abdominal ultrasound	[ ] Normal [ ] Abnormal	
	Cholesterol	[ ] Normal [ ] Abnormal	
	Colonoscopy	[ ] Normal [ ] Abnormal	
	Diabetes / A1c	[ ] Normal [ ] Abnormal	
	Eye exam	[ ] Normal [ ] Abnormal	
	Mammogram	[ ] Normal [ ] Abnormal	
	Osteoporosis / DEXA	[ ] Normal [ ] Abnormal	
	Pap smear	[ ] Normal [ ] Abnormal	
	Prostate / PSA	[ ] Normal [ ] Abnormal	

Additional information or concerns: