GA–PCOM

Georgia Osteopathic Care Center

Medical History

Please print the following information:

Today's date _____

Name _____ DOB: _____ / _____ / _____

Occupation _____ Education _____

Medications you are currently taking _____

Allergies (including medication) _____

Please describe your diet:

Breakfast _____ Lunch _____

Dinner _____ Exercise _____

Personal Medical History

Place a **check** ☑ next to those conditions that you have had in the past and that are no longer present. **Circle** those conditions that you are currently experiencing. **Indicate the age** of onset of these conditions.

- ☐ 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
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath lying flat
- ☐ Chest pain
- ☐ Heart murmers
- ☐ 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
- ☐ Excess 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
- ☐ Other _____
- ☐ # of pregnancies _____
- ☐ # of live births _____
- ☐ # of miscarriages _____
- ☐ Method of birth control _____
- ☐ Age of onset of menses _____
- ☐ Irregular period
- ☐ Light flow
- ☐ Medium flow
- ☐ Heavy flow
- ☐ Length of flow _____
- ☐ Length of cycle _____
- ☐ Pain / bleeding with intercourse
- ☐ PMS (medium / severe)

Hospitalizations

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

First _____

Second _____

Third _____

Fourth _____

Additional information _____

_____

Family Medical History

Place a check next to any condition that has been suffered by a blood relative and indicate which relative(s).

- ☐ Allergies
- ☐ Arthritis
- ☐ Diabetes
- ☐ Genetic disease
- ☐ Stroke
- ☐ Kidney / bladder problems
- ☐ Blood clotting
- ☐ Asthma
- ☐ Cancer
- ☐ Epilepsy
- ☐ Gout
- ☐ Ulcers
- ☐ Mental illness
- ☐ High blood pressure
- ☐ Alcoholism
- ☐ Glaucoma
- ☐ Headaches
- ☐ Tuberculosis
- ☐ Heart disease
- ☐ Anemia

Signature _____