Orange County Senior Care

Medical History Form

Name:_____ **Date of Birth:** _____ **Today's Date:** _____

Local Pharmacy Name: _____ **Address:**_____

Mail Order Pharmacy Name: _____ **Fax:**_____

Medications: ☐ **I do not take any medications**

Include all prescriptions, over-the-counter medications, birth control, vitamins, herbal supplements.

Medication Name / Dosage / Frequency

_____

_____

Allergies: List all known allergies (drug, food, etc) and reaction: ☐ **No known Allergies**

_____

Chronic Problems / Year of Onset: (Examples include: Diabetes, Hypertension, Heart Disease, etc.)

_____

_____

_____

Prior Surgeries and Hospitalizations / Year of Onset:

_____

_____

_____

Family History:

Please check if any family member has had any of the following conditions. ☐ **Unknown** ☐ **Adopted**

Family Member	Good Health	Heart Disease (Age of Onset)	Hypertension (Age of Onset)	Stroke (Age of Onset)	Cancer type (Age of Onset)	Other Illness (Age of Onset)
Father						
Mother						
Grandfather (Paternal)						
Grandmother (Paternal)						
Grandfather (Maternal)						
Grandmother (Maternal)						
Brother						
Sister						
Other						
Other						

Name:_____ **Date of Birth:** _____ **Today's Date:** _____

Social History:

1. Please briefly describe your occupation:

   _____

2. Please briefly describe your living situation, i.e. who lives in your house/apartment and relationship to you?

   _____

3. Tobacco Use: ☐ Current ☐ Former ☐ Never Cigarettes/day: ____ Years used: ____ Year quit?_____
   *** If you are currently smoking, are you ready to quit?**_____

4. Alcohol Use: ☐ Yes ☐ No ☐ Former Amount: _____ How often?_____

5. Exercise / Activity: ☐ Yes ☐ No Type: _____ Frequency/How often?_____ Hours per week? _____

6. **Advance Directives:** Allows a patient to state choices for healthcare and name someone to make choices if he/she is unable to do so.
   ☐ None ☐ Advanced Health Care Directive ☐ POLST ☐ Living Will

Confidential Information:

Recreational Drugs: ☐ Yes ☐ No ☐ Former Drug Type: _____
How often: _____

*** Do you have concerns for your safety?** _____

Health Maintenance Exam:	**Year**
☐ **Mammogram**	**I**
☐ **Pap smear**	**I**
☐ **Colonoscopy**	**I**
☐ **Bone Density**	**I**
☐ **Eye Exam**	**I**
☐ **Dental Exam**	**I**

Immunizations	**Year**
☐ **HPV (Gardasil)**	**I**
☐ **Tdap (Tetanus)**	**I**
☐ **Influenza**	**I**
☐ **Shingles (Zostavax)**	**I**
☐ **Pneumovax (Pneumonia)**	**I**
☐ **Tetanus**	**I**
☐ **Other**	**I**
☐ **PPD**	**I**
☐ **PPD Positive** ☐ **PPD Negative**	

Reviewed by:_____ _____
Name, Title **Date**