BMC

MEDICAL HISTORY FORM

NAME: _____ DATE: _____

Buellton Medical Center will be billing your insurance for an office visit for any other medical issue that might come up at the time of your wellness exam. Therefore you might be responsible for any copays, co-insurance or deductible after your insurance responds. Please Initial: _____

Please list any previous surgeries or hospitalizations including dates of occurrence:

_____

_____

_____

Medical History: (Circle items that apply to you)

Allergies	Anemia	Arthritis	Asthma
Back problems	Bleeding disorder	Cholesterol disorder	Depression
Diabetes	Hearing problems	Heart Disease	Heart Murmur
HIV/Hepatitis	Hypertension	Lung Disease	Kidney Disorder
Prostate disorder	Seizures	Skin Cancer	other Skin problems
Stomach/Digestive disorders		Stroke	Thyroid problems
Vision Problems	Cancer (specify type) _____		

Other/ Additional Information_____

_____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Alcohol use: Never Rarely Moderate Daily

Tobacco use: Never Quit Currently smoke_____packs/day Year you started smoking_____

Drug use: Never Type/Frequency _____

Excessive exposure at work/home to: Fumes Dust Solvent Noise Air-born particles

Occupation/Location: _____

Family History:

Father: Age _____Living/Deceased- Cause of death or medical probs_____

Mother: Age _____Living/Deceased- Cause of death or medical probs_____

Bro/Sis Age _____Living/Deceased- Cause of death or medical probs_____

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Bro/Sis Age _____Living/Deceased- Cause of death or medical probs_____

Bro/Sis Age _____Living/Deceased- Cause of death or medical probs_____

Any other physicians involved in your care? _____

_____

_____

NAME: _____ DATE: _____

SYSTEM REVIEW

Circle the symptoms/illnesses that you have or have had.

General
Recent Weight change
Fever
Fatigue
Headache

Integumentary (skin/breast)
Rash or itching
Change in skin color
Change in hair or nails
Varicose veins

Eyes
Eye disease or injury
Glasses/Contact lenses
Blurred/double vision
Glaucoma

Ears/nose/throat/Mouth
Hearing Loss or ringing
Earaches or drainage
Chronic sinus problems
Nose bleeds
Mouth sores
Bleeding gums
Bad Breath or bad taste
Sore throat or voice change
Swollen glands in neck

Respiratory
Chronic or frequent cough
Spitting up blood
Shortness of breath
Asthma or wheezing

Cardiovascular
Heart trouble or murmur
Chest Pain
Palpitation
Shortness of breath
Swelling of feet, ankles or hands
High or Low Blood Pressure

Gastrointestinal
Loss of appetite
Change in bowel movements
Nausea or vomiting
Frequent diarrhea
Constipation/blood in stool
Abdominal pain or heartburn
Peptic ulcer

Genitourinary
Frequent urination
Burning/painful urination
Blood in urine
Force/strain in urination
Incontinence/dribbling
Kidney stones
Sexual difficulty

Musculoskeletal
Joint stiffness
Joint Pain
Muscle weakness
Back pain
Cold extremities
Difficulty walking
Muscle pain/cramps

Neurological
Frequent Headaches
History of Concussion
Light headed/dizzy
Seizures
Numbness/tingling
Tremors
Paralysis
Stroke
Head Injury

Endocrine
Glandular/hormone problem
Thyroid disease
Diabetic
Excessive thirst/urination
Heat or cold intolerance
Dry Skin
Change in hat or glove size

Hematological/Lymphatic
Slow to heal after cuts
Bleeding or bruising
Anemia
Phlebitis
Past Transfusion
Enlarged glands
Hepatitis A B C/HIV

Please list your Allergies

_____
_____
_____
_____
_____

Please list your Medications

_____
_____
_____
_____
_____
_____
_____
_____
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