AstranaCare

# Past Medical History

**DEMOGRAPHICS:**

**Race:** ☐Asian ☐ African American ☐ White ☐ Other _____

**Ethnicity:** ☐Hispanic ☐ Non-Hispanic ☐ Declined

**Pharmacy/Address/Phone #:** _____

**PAST MEDICAL HISTORY:** *Check & indicate age when you had any of the symptoms or diseases below*

| | | | |
|---|---|---|---|
| ☐ Abdominal Pain | ☐ Heart Attack | ☐ Osteoporosis | ☐High Cholesterol |
| ☐ Pneumonia / Pleurisy | ☐ Anemia | ☐ Hives | ☐ Polio |
| ☐ Back pain | ☐ Hoarseness Prolonged | ☐ Rashes | ☐ Bloody or Tarry Stools |
| ☐ HTN | ☐ Rheumatic Fever | ☐ Bone Fracture | ☐ Jaundice |
| ☐ Rheumatoid Arthritis | ☐ Cancer | ☐ Joint Injury | ☐ Ringing in Ears |
| ☐ Chest Pain | ☐ Kidney Stones | ☐ Scarlet Fever | ☐ Chicken Pox |
| ☐ Difficulty Walking | ☐ Seizures | ☐Diabetes Type I or II | ☐ Loss of Appetite |
| ☐ Shortness of Breath | ☐ Difficulty Swallowing | ☐ Measles / Mumps | ☐ Skin Problems |
| ☐ Frequent Ear Infections | ☐ Mental Illness | ☐ STD | ☐ Frequent Eye Infections |
| ☐ Migraines | ☐ Swollen Ankles | ☐ Foot Pain | ☐ Moodiness |
| ☐ Thyroid Disease | ☐ GERD | ☐ Muscle Weakness | ☐ Urination Issues |
| ☐ Hay Fever / Allergies | ☐ Nervousness | ☐ Hemorrhoids | ☐ Recent Weight Loss |
| ☐ Recurrent Nose Bleeds | ☐ Wheezing | ☐ Hernia | ☐ Alcohol ____ oz. / week |
| ☐ Smoking<br>_____ # cigarettes / day | ☐ Tea / Coffee<br>____# cups / day | ☐ Other<br>_____ | _____ |

AstranaCare

**PAST SURGICAL HISTORY:**

Have you been hospitalized in the last 3 years? ☐ YES ☐ NO

Please note date(s) of surgery: _____

**MEDICATION LIST**:

List both prescribed & over the counter: _____ ☐ No Current Medication

Are you allergic to any medications? ☐ YES ☐ NO Are you allergic to any foods? ☐ YES ☐ NO

**FAMILY MEDICAL HISTORY:** (Mother, Father, Grandmother/Father, Son, Daughter, Aunt, Uncle, Cousins)

***Check all that apply***

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Cardiovascular Disease | ☐ Hemophilia | ☐Migraines |
| ☐ Anemia | ☐ Diabetes | ☐ Hepatitis | ☐ Osteoporosis |
| ☐ Arthritis | ☐ Epilepsy / Seizures | ☐ Hypertension | ☐ Renal Failure |
| ☐ Asthma | ☐ Glaucoma | ☐ Kidney Disease | ☐ Stroke |
| ☐ Cancer | ☐ Heart Disease | ☐ Mental Illness | ☐ Thyroid |
| ☐ Other _____ | _____ | _____ | _____ |

**MALES ONLY:** Date of Last Prostate Exam: _____

**FEMALES ONLY:**

Date of Last Pelvic Exam: _____ Date of Last Mammogram: _____

Date of Last Pap Smear: _____ Date of Last Breast Exam: _____

Length of Menstrual Flow: _____

Last Period: _____ ☐ Pain / Cramps ☐ Normal ☐ Abnormal

Birth Control Method: _____ Number of Pregnancies: _____

Number of Miscarriages (& Date): _____ Number of Abortions: _____

Other: ☐ Pain / Bleeding During Sex ☐ Flushing / Menopause

**Client Signature:** _____ **Date:** _____