Mulberry Clinic
Spring Hill

Patient Medical History Form

First Name:	Last Name:	Birth Date:
Married? Yes No	Spouse Name:	Your Occupation:
Children's Names Ages:		
Preferred Pharmacy (if medication not available at Mulberry Clinics):		

Allergies to Medications, Latex, or Dyes	Yes	No	If yes, please list:

Current Medications (Prescriptions, Non-Prescriptions)	Yes	No	If yes, please list:

Your Health History (Please check all that apply):						
ENT		GENITOURINARY			SKIN	
	Eve Problems		Urinary Infections		Psoriasis	
	Sinus Problems		Kidney Disease!Stones		Skin Disorders	
	Hearing Loss		Erectile Dysfunction		Melanoma	
			STD			
CARDIOVASCULAR			Urinary Incontinence			
	Abnormal EKG	MUSCULOSKELETAL		PSYCH		
	Chest Pain		Arthritis, Osteo		ADD ADHD	
	Heart Attack		Arthritis, Rheumatoid		Anxiety	
	Heart Disease		Gout		Depression	
	High Blood Pressure		Neck Spinal Problems		Memory Loss	
	High Cholesterol	NEUROLOGICAL			OCT)	
	Stroke		Concussion		Suicidal Thoughts, Attempts	
	Peripheral Vascular Disease		Headaches	Allergies		
PULMONARY			Migraines			
	Asthma		Epilepsy Seizures	OTHER		
	Emphysema COPD	HEMATOLOGICAL				
	Shortness of Breath		Anemia			
	Sleep Apnea		Bleeding Disorders			
GASTROINTESTINAL			Blood Clots			
	Acid Reflux		Cancer			
	Constipation	ENDOCRINE				
	Diarrhea		Diabetes			
	Irritable Bowel		Thyroid Disease			
	Gallbladder Disease		Pancreatitis			
	Hernia					
	Liver Disease					

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Health Maintenance	NO	YES	YEAR			NO	YES	YEAR
Colonoscopy					Bone Density			
Mammogram					Pap Smear			
Physical Exam					Current Height and Weight			

PAST SURGERIES (include date):	

SOCIAL HISTORY	NO	YES				NO	YES
Smoking			Pack(s) Day:		When did you quit?		
Alcohol			Drinks/ Day:	Drinks Week:			
Recreational Drugs							
Special Diet			If yes, describe:				
Regular Exercise			If yes, describe:				

FAMILY HISTORY (please check all applicable boxes):

ILLNESS	Father	Mother	Sibling	Child	
Asthma					
Bleeding Disorders					
Breast Cancer					
Colon Cancer					
Depression 'Anxiety					
Diabetes					GYN/OB HISTORY
Drug Alcohol Addiction					Menopause? Yes No If yes, age:
Heart Disease					Abnormal Pap'? Yes No If yes, approx. date:
High Blood Pressure					Total # of pregnancies:
High Cholesterol					
Kidney Disease					
Leukemia					
Liver Disease					
Lung Cancer					
Osteoporosis					
Os arian Cancer					
Pancreatic Cancer					
Rheumatoid Arthritis					
Stroke					
Thyroid Disease					
Other:					

IMMUNIZATIONS	NO	YES		NO	YES
Hepatitis B Series			Recent Pneumonia Vaccine		
Gardasil Series			Recent Flu Vaccine		
Chicken Pox Immunization or disease			Shingles Vaccine		

COMMENTS / ADDITIONAL INFORMATION