MyMD Direct, PLLC
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Charlotte, NC 28226
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PERSONAL HEALTH HISTORY

Full Name: ____

How would you prefer to be addressed? (Mr./Ms., Nickname, etc.): ____________________

Street Address: _________________________________

City:___________________________State:__________Zip Code:________________

Preferred Phone Number:________________________

Is it okay to leave a detailed message on this number? Yes_____No ______

Birthdate: _________________

Insurance Name: _________________________________

Insurance ID & Group Number:_________________________

Effective Date:__________________

Preferred Email _______________________________________

Emergency Contact Name/Phone Number/Relationship: _____________________________

Emergency Contact Phone Number/Relationship __________________________________

Preferred Local Hospital System:____

Pharmacy Name:______________________________

Number/Fax: ____________________________

Address/Location:____

Height:______________Usual Weight: ____________

INTRODUCTION:

How did you learn about our office? Please check all that apply or fill in "Other" section.

Online Search____ Friend/Family_____Local Event_____Social Media _____Other____________________

How would you describe your health? ____

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MEDICAL HISTORY:

Please list all medical problems, including conditions that have resolved or are controlled with medications (i.e. high blood pressure). Please include the approximate date it began. Examples may include: high cholesterol, diabetes, cancer, heart attack, stroke, etc.

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MEDICATIONS:

Please list all **prescription** and **nonprescription** (over the counter) medications, as well as any **supplements**. Okay to include on a separate sheet of paper if you have a pre-printed list.

Name	Dose (mg or ?)	How often (daily, twice daily)	Purpose
____________	________	____________	____________
____________	________	____________	____________
____________	________	____________	____________
____________	________	____________	____________
____________	________	____________	____________

PAST MEDICATIONS:

Are there any medications you have taken in the past? Yes______No _______

Medication(s)____

Why were they stopped? ____

ALLERGIES: Please list all medication allergies, including your reaction. Also list any food or environmental allergies:____

____

REVIEW OF SYSTEMS: Please list any symptoms that bother you, from head to toe. (For example: dry eyes, skin rash on arm, heartburn after meals, back pain etc.)

GENERAL (Weight, sleep energy level etc.): _______________________________

SKIN:____

HEAD, NECK: ____

EARS, EYES, THROAT: ____

RESPIRATORY:____

CARDIAC/HEART:____

GASTROINTESTINAL:____

GENITAL/URINARY: ____

MUSCULOSKELETAL (back, limbs, joints, muscles):_______________________________________

NEUROLOGIC:____

PSYCHIATRIC:____

OTHER: ____

CARE PROVIDERS:

Please list any medical/healthcare professionals involved in your care, including doctors, dentists, eye doctors, massage therapists, chiropractors, specialists, etc. (Please include a phone number and fax number when possible.)

Name:____Phone:________________________________

Name:____Phone:________________________________

Name:____Phone:________________________________

Name:____Phone:________________________________

Name:____Phone:________________________________

ADVANCE DIRECTIVES:

Please list who you would want called in the event of an emergency.

Name:____Phone:________________________________

Name:____Phone:________________________________

Also list who you would want to make decisions for you if you are unable to speak for yourself.

Name:____Phone:________________________________

Name:____Phone:________________________________

Do you have an advance directive, either a living will, Healthcare Power of Attorney or both? If so, please bring a copy for your electronic medical record. This can be submitted electronically by email or by paper for scanning into your record.

HEALTH SCREENING TESTS: Please list the date of each test below when applicable.

Eye Exam: __________________

Dental Exam: ________________

Hearing Exam: ________________

EKG: ________________

Colonoscopy:___________________

Flu Shot: ________________

Tetanus shot: ________________

Pneumonia shot: ________________

Shingles shot: ________________

Mammogram (females): ________________

Pap Smear (females): ________________

PSA (prostate lab test) (males): ________________
Sleep Study: ________________
Pulmonary Function Test: ________________
Echocardiogram: ________________

SURGICAL HISTORY:

Please list surgeries you have had, their approximate date, hospital, and name of the surgeon.

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HOSPITALIZATIONS: Please list any times other than surgery you have stayed overnight in the hospital, the date, reason, and which hospital. ____

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FAMILY HISTORY: Please note your first-degree family members (parent, sibling, child) and any health conditions they have/had.

Mother:____

Father:____

Sister/Brothers:____

Child:____

Maternal grandmother: ____

Maternal grandfather: ____

Paternal grandmother: ____

Paternal grandfather: ____

Also note if there are any health conditions which have occurred in multiple family members (cousins, aunts, uncles, grandparents) For example: cancer (what kind?), heart attack, stroke, high blood pressure, diabetes, high cholesterol, blood disorders, anxiety/depression/bipolar, etc.

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REPRODUCTIVE HEALTH HISTORY:

If female, please answer the following:

Do you have any menstrual problems? Yes______No_________

Date of the last pelvic exam/Pap smear? __________________

Do you have any history of abnormal Pap smears? Yes______No________

If yes, year: ________________________

Colposcopy? Yes______No _______

If yes, year: ________________________

LEEP? Yes______No _______

If yes, year: ________________________

How many times have you been pregnant?____________times

How many children do you have?____________children

If applicable, age of menopause? __________

Are you or have you been on hormone replacement therapy? Yes______No _______

If yes, what medications have you taken? ____

Any other Gyn procedures (eg: uterine ablation, hysterectomy)? ____________________________

Are you currently on or have you been on any medication to prevent pregnancy?

Yes______No________If yes, please specify: ____

Comments/Further Concerns: ____

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If male, please answer the following:

Do you have any penile or testicular concerns? Yes______No _______

If yes, explain: ____

Have you had any urological surgeries? Yes______No _______

Have you had any prostate problems? Yes______No _______

If applicable, date of last prostate exam? ____________________

Comments/Further Concerns: ____

____

SOCIAL HISTORY:

Where are you from? ____

What is your family race/ethnicity background? ____

How much schooling have you had (high school, college, grad school)? ______________________

Are you married, single, domestic partner, or divorced? ___________________________________

Do you have children, and if so, what are their ages? _____________________________________

What type of work do you do? ____

SOCIAL HISTORY: (continued)

Do you have a spiritual or religious practice? ______________________________

Is there a specific clergy person you would want to be involved in or aware of your care if you were hospitalized? If so, name: ______________________________

RECREATIONAL DRUG USE:

Do you smoke (how many packs per day, year started & year quit)? ______________________________

____

How much alcohol do you drink per day or week now and in the past & types? ______________________________

____

____

Do you use, or have you used, marijuana for recreation or medicinal purposes? Have you used any other types of recreational/illicit drugs? Please remember, this is private and CONFIDENTIAL!

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PSYCHIATRIC HISTORY:

What are your stressors? ______________________________

What do you do to relieve stress? ______________________________

Do you feel depressed or anxious? ______________________________

Have you ever been formally diagnosed with any condition, or been in the care of a psychiatrist in a clinic or in the hospital?______________________________

____

DIET:

What kinds of foods do you usually eat for breakfast, lunch, or dinner?______________________________

____

Do you take any nutrition supplements? ______________________________

____

Are there any specific foods you avoid, and if so, why? ______________________________

____

ACTIVITY:

What kinds of exercise or physical activity do you do? How often and for how long (duration)?

____

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SAFETY CONCERNS:

Do you always wear a seat belt when you drive? Yes______No_______

Do you always wear a bike helmet? Yes______No _______

Do you keep firearms in your home? Yes______No _______

If yes, are they stored in a locked place? Yes______No_______

Do you have working smoke detectors? Yes______No _______

Do you have a working carbon monoxide detector? Yes______No_______

Do you feel safe in your neighborhood? Yes______No _______

Is there anyone in your life now or in the past who says or has said abusive things to you or has physically harmed you? Yes______No _______

Do you have problems with walking or falls? Yes______No _______

Do you or anyone in your life have concerns about your driving safety? Yes______No _______

EXPOSURE HISTORY:

Have you ever been exposed to chemicals, irritants, or pollutants in the past? (For Example: Lead-based paint, water-damaged building with mold, living in an area exposed to pesticides or radiation, or working in a place with chemicals, animals, or radiation.) If yes, please explain: ________________

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