Medical History

Terry Westmoreland, M.D.
Misty Sharp, M.D.
Paula Hardy, FNP-BC
Gwen Hill, FNP-BC
Today's Date_____

Patient Name_____

Date of Birth_____

What is the primary reason for your visit today?_____

Primary Care Physician_____

Did a Physician's office schedule this appointment for you or refer you to this office? YES NO

If yes, Physician's Name_____

FEMALE PATIENTS ONLY: Are you currently pregnant or could be pregnant? YES NO
Are you currently breastfeeding? YES NO

CURRENT MEDICATIONS (*Please list, including over the counter medicines, vitamins & herbs*)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Others_____

Pharmacy_____

DRUG ALLERGIES
Name of Drug & type of reaction

1._____

2._____

3._____

4._____

PAST SURGERIES
Surgery When?

1._____

2._____

3._____

4._____

*****Please provide your nurse with this medical history form when called back for your evaluation.*****

PAST MEDICAL HISTORY *PLEASE CHECK THE PROBLEMS YOU HAVE HAD*

_____Allergies (seasonal)
_____Anemia
_____Arthritis
_____Artificial Heart Valve
_____Artificial Joints
_____Asthma
_____Bleeding Disorder
_____Cancer Type
_____Congestive Heart Failure
_____Diabetes
_____Depression
_____Drug Abuse
_____Drug Addiction
_____Eczema
_____Gallbladder Disease
_____Gastrointestinal Disease
_____Glaucoma
_____Hearing Impairment
_____Heart Attack
_____Heart Disease
_____Heart Murmur
_____Heart Surgery
_____Hepatitis
_____High Blood Pressure
_____High Cholesterol
_____HIV/AIDS
_____Joint Surgery
_____Keloids
_____Kidney Problems
_____Lupus/auto-immune Disease
_____Menstrual Dysfunction
_____Mitral Valve Prolapse
_____Osteoporosis
_____Psychiatric Condition
_____Prostate Problems
_____Psoriasis
_____Rosacea
_____Seizures
_____Stroke
_____Thyroid Disease
_____Vascular Disease

Do you have any disease, condition or problem not listed? If so, please describe
_____
_____

Do you have a history of skin cancer? YES NO
If so, what type and location (*i.e. Squamous on the neck*)_____
How and where was it treated?_____

Do you smoke? YES NO Former Smoker? What year did you quit?_____
If you marked yes, are you interested in information about quitting? YES NO

Do you use alcohol? YES NO If yes, how often? Daily, Weekly, Monthly

Do you have a pacemaker? YES NO

Did you receive the flu vaccine between October1 – March 31? YES NO

If you are over the age of 65, have you had the pneumonia vaccine? YES NO

Do you have a living will (Advanced Care Plan) YES NO

FAMILY HISTORY (*Please circle*)
Is there a family history of skin cancer? YES NO Type_____
Is there a family history of melanoma? YES NO Type_____
Is there a family history of any skin disorder? YES NO Type_____
Is there a family history of - cancer, diabetes, high blood pressure, or heart disease? Please Circle

If I have a change of health, I will inform my physician of this at my next appointment.

_____ ____/____/____ _____
Signature of Patient Date Terry Westmoreland, M.D.
(Parent or Guardian if Child or Minor) Misty Sharp, M.D.
Paula Hardy, FNP-BC
Gwen Hill, FNP-BC

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OFFICE USE ONLY

(Not necessary for patient to fill out)

Height_____ Weight_____ BP_____