PCOM Georgia

Georgia Osteopathic Care Center

Medical History

Please print the following information:

Today's Date _____

Name _____ Birth Date _____

Occupation _____ Education_____

Medications you are currently taking _____

Allergies (including medication) _____

Please describe your diet:

Breakfast _____

Lunch _____

Dinner _____

Exercise _____

Personal Medical History

*Place a **check** next to those conditions that you have had in the past and that are no longer present. **Circle** those conditions that you are currently experiencing. Indicate the age of onset of these conditions.*

- ☐ Failing Vision
- ☐ Double or blurred vision
- ☐ Eye Pain
- ☐ Eye Infections
- ☐ Decreased Hearing
- ☐ Ringing / Buzzing in ears
- ☐ Ear Infections
- ☐ Allergies / Hay fever
- ☐ Sinus Trouble
- ☐ Nose Bleeds
- ☐ Frequent Sore Throats
- ☐ Prolonged Hoarseness
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Alcoholism
- ☐ Shortness of Breath on Exertion
- ☐ Shortness of Breath Lying Flat
- ☐ Chest Pain
- ☐ Heart Murmurs
- ☐ Palpitations
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain when walking
- ☐ Varicose Veins / Phlebitis
- ☐ Recent loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Persistent Nausea / Vomiting
- ☐ Ulcers
- ☐ Chronic Abdominal Pain
- ☐ Recent Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or Tarry Stool
- ☐ Red Blood in stools
- ☐ Hemorrhoids
- ☐ Diverticulitis
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Hernia
- ☐ Bladder Infections
- ☐ Kidney Infections
- ☐ Pain on Urination
- ☐ Poor Control of Urination
- ☐ Decreased Force of Urination
- ☐ Blood in Urine
- ☐ Kidney Stones

- ☐ STD
- ☐ Chronic Fatigue
- ☐ Recent Weight loss
- ☐ Excessive Weight Gain
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Muscle Weakness
- ☐ Numbness / Tingling sensation
- ☐ Frequent Headaches
- ☐ Arthritis
- ☐ Gout
- ☐ Cold or Numb Feet
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Difficulty Sleeping
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness
- ☐ Phobias
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Chicken Pox
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Recreational Drug Use
- ☐ Alcohol _____
- ☐ Cigarettes _____ Packs per day
- ☐ Coffee/Tea _____Cups per day
- ☐ Other _____
- ☐ # Pregnancies:_____
- ☐ # Live Births: _____
- ☐ # Miscarriages: _____
- ☐ Method of Birth Control_____ _
- ☐ Age of Onset of Menses: _____
- ☐ Irregular Period
- ☐ Light Flow
- ☐ Medium Flow
- ☐ Heavy Flow
- ☐ Length of Flow: _____
- ☐ Length of Cycle _____
- ☐ Pain / Bleeding with Intercourse
- ☐ PMS: (Medium/Severe)

Hospitalizations

Please indicate Year, Operation/ Illness, Hospital, City/State

First _____

Second _____

Third _____

Fourth _____

Additional information: _____
_____
_____
_____

Family Medical History

*Place a **Check** next to any condition that has been suffered by a blood relative and indicate which relative*.

- ☐ Allergies
- ☐ Arthritis
- ☐ Diabetes
- ☐ Genetic
- ☐ Disease
- ☐ Stroke
- ☐ Kidney / Bladder Problems
- ☐ Blood Clotting
- ☐ Asthma
- ☐ Cancer
- ☐ Epilepsy
- ☐ Gout
- ☐ Ulcers
- ☐ Mental Illness
- ☐ High Blood Pressure
- ☐ Alcoholism
- ☐ Glaucoma
- ☐ Headaches
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Anemia

Patient Signature: _____ ***Date:*** _____