Mallory Osteopathic family practice
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Personal Medical History: Do you have or have you had any of the following:

☐ High blood pressure ☐ Diabetes ☐ High cholesterol ☐ Stroke
☐ Heart attack ☐ Heart failure ☐ Abnormal heart rhythm
☐ Thyroid disorder ☐ Cancer (Specify: _____)
☐ Blood clots in the legs or lungs ☐ Asthma ☐ Emphysema ☐ COPD
☐ Depression ☐ Other psychiatric problem: (_____)
☐ Alcohol or substance abuse: (_____)
☐ Other: (_____)

Females:
How old were you when you started having periods: _____
Are your periods regular: ☐ Yes ☐ No (If no, please describe: _____)
How long do your periods last: _____
How long do you go between periods: _____
How old were you when you stopped having periods: _____
How many times have you been pregnant: _____
Have you ever had any abnormal PAP smears: ☐ No ☐ Yes (If yes, please expand: _____
_____)
How many babies have you delivered: _____ How many pregnancies have you lost: _____

Medications: Please list the medications that you are currently taking, including over-the-counter medicines.

Medication	Dose	How often do you take it

(Continue on reverse if needed.)

Allergies: ☐ Seafood/Shellfish ☐ "Hay fever" ☐ Dust ☐ Pollen ☐ Grass
☐ Cats ☐ Dogs ☐ Other: (please specify: _____)

Please list any medications that you are allergic to and what the reaction is that you have to them.

Medication	Reaction

Patient's Name & DOB: _____ Date: _____

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Surgical History: Please list all surgeries (operations) that you have had. (continue on reverse if needed)

Operation	Date	Hospital/Location

Family History: Please check the boxes if you have family members who have or have had the following:
(Indicate in the space what family member it is/was using M= Mother, F= Father, B= Brother, S= Sister, PGF= Paternal Grandfather, MGM= Maternal Grandmother, MA= Maternal Aunt, PU= Paternal Uncle etc.)

☐ High blood pressure_____ ☐ Diabetes _____
☐ High cholesterol _____ ☐ Stroke _____
☐ Heart attack _____ ☐ Heart failure _____
☐ Abnormal heart rhythm _____ ☐ Thyroid disorder _____
☐ Cancer (specify: _____)
☐ Blood clots in the legs or lungs _____ ☐ Asthma _____
☐ Emphysema _____ ☐ COPD _____
☐ Other _____

Social History:

What is your occupation: _____
Are you ☐ Married ☐ Single ☐ Divorced
Please list your family members below from oldest to youngest (continue on reverse if needed):
Spouse / Significant Other: (name) _____ (age) _____
☐ Son / ☐ Daughter : (name) _____ (age) _____
☐ Son / ☐ Daughter : (name) _____ (age) _____
☐ Son / ☐ Daughter : (name) _____ (age) _____
☐ Son / ☐ Daughter : (name) _____ (age) _____
Do you live ☐ alone ☐ with family (please circle the family members you live with or list them below)
_____
_____

Do you use or have you used tobacco ☐ No ☐ Yes (☐ cigarettes ☐ cigars ☐ smokeless ☐ pipe)
How many cigarettes do you smoke per day: _____
How long have you smoked / did you smoke: _____
How much smokeless tobacco do/did you use: _____
How long have you used / did you use smokeless tobacco: _____
Do you drink alcoholic beverages ☐ No ☐ Yes (How many drinks per week _____)
Do you use or have you used "street drugs": _____

Patient's Name & DOB: _____ Date: _____

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Review of Systems: Please indicate if you have any of the following by checking the boxes (☒). Boxes left empty are assumed to reflect an answer of "No, I do not have this."

Consitutional: ☐ Fevers ☐ Drenching night sweats ☐ Chills ☐ Swollen glands

Cardiovascular: ☐ Abnormal heart beat/palpitations ☐ Chest pain
☐ Difficulty breathing ☐ Swelling in the arms or legs

Heme: ☐ Easy bruising ☐ Prolonged bleeding

Respiratory: ☐ Shortness of breath ☐ Difficulty breathing ☐ Easily winded
☐ Cough ☐ Wheezing

GI: ☐ Constipation ☐ Diarrhea ☐ Blood in your stool ☐ Heart burn
☐ Difficulty swallowing ☐ Incontinence of stool

Urinary: ☐ Pain on urination ☐ Blood in your urine ☐ Abnormal urine stream
☐ Incontinence of Urine

Neurologic: ☐ Headaches ☐ Dizziness ☐ Numbness or tingling
☐ Difficulty with memory or thought processes

Vision: ☐ Blurred vision ☐ Double vision ☐ Loss of vision ☐ Glasses/contacts

ENT: ☐ Chronic runny nose ☐ Chronic nasal congestion ☐ Itchy / watery eyes
☐ Recurrent sinus headaches or infections

Musculoskeletal: ☐ Back pain ☐ Neck Pain
☐ Joint pain (specify: _____)
☐ Other pain: _____

Reproductive: ☐ Pain with intercourse ☐ Inability to get / maintain an erection
☐ Difficulty getting pregnant ☐ Other: _____

Skin: ☐ Rash ☐ Moles or pigmented spots that have changed ☐ New skin lesions

Patient's Name & DOB: _____ Date: _____

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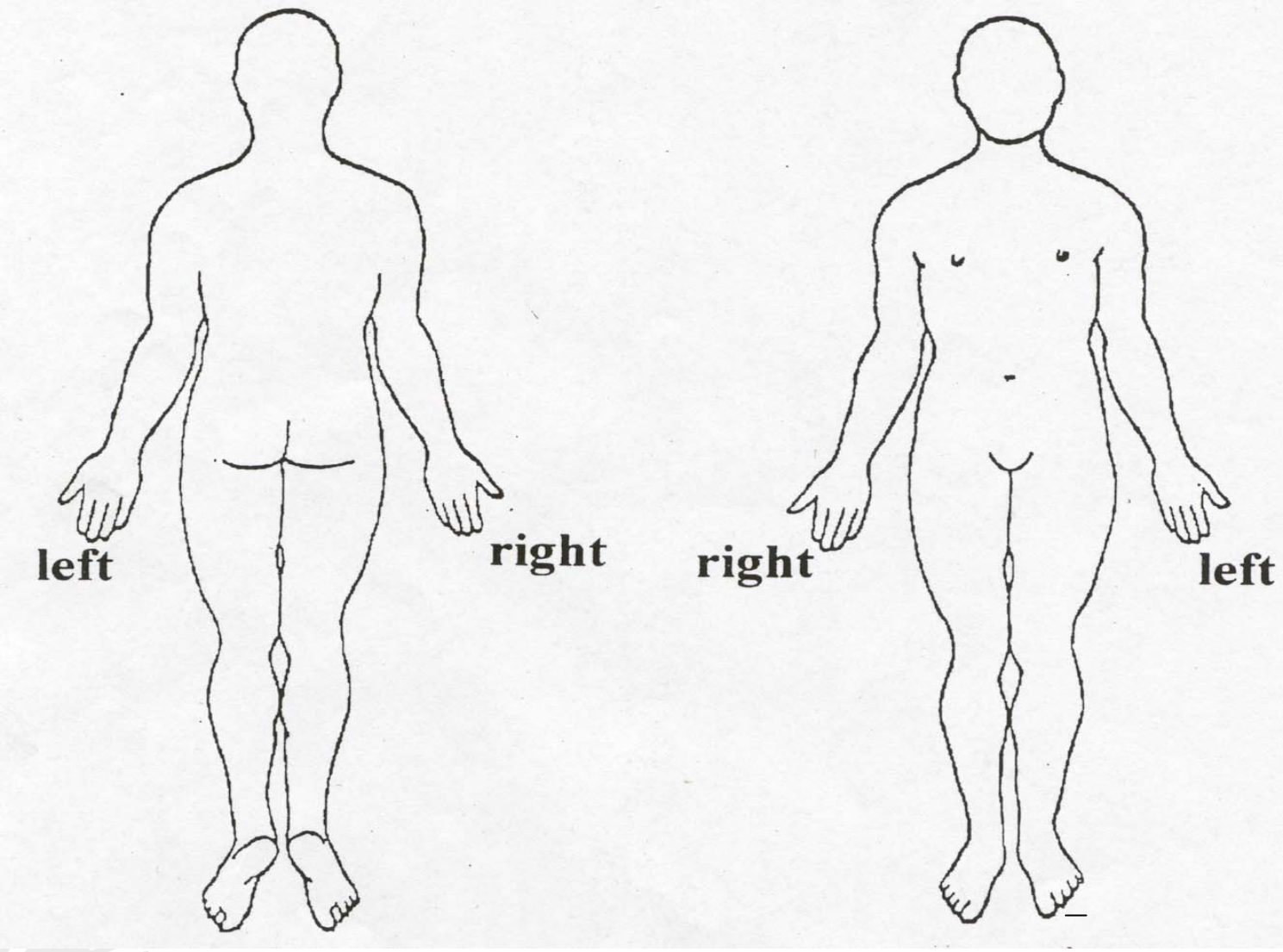
Briefly describe your injury, pain, or the reason for your visit. (Continue on reverse if needed.)

_____
_____
_____
_____

PAIN DIAGRAM

Draw the location of your pain on the body outlines below. Use the appropriate colors to denote the quality of the pain that you experience. Using a pen, draw all of the scars that are on your body.



On a scale of 1 to 10, with 1 being little to no pain and 10 being the worst pain you can imagine, please rate

A) The average intensity of your pain on a daily basis: _____
B) How intense your pain gets when it is at its worst: _____

Patient's Name & DOB: _____ Date: _____

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