



Madison Medical Associates, P.C.
 David T. Fletcher, M.D.
 1075 S. Main Street Suite 100
 Madison, GA 30650

Name _____

Medical Record# _____ Page# _____

Patient History Form

Today's Date ____/____/____

Legal name _____ Age _____ Birthdate: ____/____/____
Last First Middle Occupation: _____ Race: _____
 Sex: Male Female Marital Status: Single Married Widowed Divorced/Separated
 Spouse/Partner's name _____ Children's names/ages _____

Has any blood relative had any of the following? Please indicate which relative(s).

- Allergies _____ Depression _____ HIV/AIDS _____ Migraine _____
- Anemia _____ Diabetes _____ Heart Disease _____ Obesity _____
- Arthritis _____ Drug/Alcoholism _____ High Blood Press _____ Stroke _____
- Asthma _____ Epilepsy _____ High Cholesterol _____ Osteoporosis _____
- Bleeds easily _____ Glaucoma _____ Kidney Disease _____ Thyroid Disease _____
- Cancer _____ Gout _____ Mental illness _____ Tuberculosis _____
- Other _____

Father's Age ____ Health: Good Fair Poor Deceased(age) ____ Siblings' Health: _____

Mother's Age ____ Health: Good Fair Poor Deceased(age) ____ Children's Health _____

Tobacco Use: Never smoked Currently smoke ____ packs per day since age ____ Ever quit? ____
 Chewing tobacco Dip snuff Quit smoking ____/____/____ after ____ packs/day for ____ yrs.
 Any smokers in home? Yes No **Any other drug use?** (list) _____

Alcohol Use: Never drink I average ____ beers; ____ glasses wine; ____ oz. liquor per week month yr.
 Stopped drinking ____/____/____ after ____ yrs. Any alcoholics in home? yes No

Caffeine Use: ____ cups of coffee/day (approx. size of cup: ____ oz.) ____ cups/glasses tea/day ____ sodas/day

Safety Issues: Do you have any guns in the home? ____ Are they kept in a locked cabinet/secured location? ____

Do you have working smoke detectors in your home? ____ % of time seatbelts used in car ____

Is there anyone in your home who physically hurts/threatens you, or makes you feel afraid? ____

Have you recently had any of the following symptoms/diseases?

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Change in appetite <input type="checkbox"/> Dizziness/fainting spells <input type="checkbox"/> Night sweats/hot flashes <input type="checkbox"/> Persistent fever <input type="checkbox"/> Recent weight changes <input type="checkbox"/> Sensitivity to heat or cold <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Tire easily or weakness <input type="checkbox"/> Double or blurred vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye infections frequent <input type="checkbox"/> Failing vision <input type="checkbox"/> Wear glasses or contacts? <input type="checkbox"/> Last eye exam ____/____/____ <input type="checkbox"/> Decrease in hearing <input type="checkbox"/> Discharge from ears <input type="checkbox"/> Ear pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Frequent nosebleeds <input type="checkbox"/> Loss of smell <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Dental problems <input type="checkbox"/> Last dental visit ____/____/____ | <ul style="list-style-type: none"> <input type="checkbox"/> Sore throat <input type="checkbox"/> Sore tongue or gums <input type="checkbox"/> Artificial heart valves <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Pacemaker <input type="checkbox"/> Palpitations or fluttering heart <input type="checkbox"/> Varicose veins <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Bronchitis-chronic <input type="checkbox"/> Chronic or frequent cough <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia/pleurisy <input type="checkbox"/> Short of breath with exertion <input type="checkbox"/> Short of breath lying flat <input type="checkbox"/> Coughing blood or phlegm <input type="checkbox"/> Last chest x-ray ____/____/____ <input type="checkbox"/> Abdominal pain-chronic <input type="checkbox"/> Bloody or back tarry stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing | <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn/indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis/yellow jaundice <input type="checkbox"/> Nausea/Vomiting-persistent <input type="checkbox"/> Ulcers <input type="checkbox"/> Vomiting up blood <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty starting urine <input type="checkbox"/> Frequent urination (day) <input type="checkbox"/> Frequent urination (night) <input type="checkbox"/> Kidney stones <input type="checkbox"/> Leakage of urine <input type="checkbox"/> Painful urination <input type="checkbox"/> Urine infections-frequent <input type="checkbox"/> Venereal disease <input type="checkbox"/> Lack of sex drive <input type="checkbox"/> Discharge from penis <input type="checkbox"/> Impotence <input type="checkbox"/> Pain or lump on testicles <input type="checkbox"/> Last period began ____/____/____ <input type="checkbox"/> Last pap/pelvic ____/____/____ <input type="checkbox"/> Last mammogram ____/____/____ <input type="checkbox"/> Age periods began ____ <input type="checkbox"/> Number of pregnancies _____ |
| <ul style="list-style-type: none"> <input type="checkbox"/> Number of live births _____ <input type="checkbox"/> Number of miscarriages _____ <input type="checkbox"/> Number of abortions _____ <input type="checkbox"/> Type of birth control _____ <input type="checkbox"/> BC pill name _____ <input type="checkbox"/> Abnormal Pap in past
Flow: <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/cramps with flow
____ days of flow
____ length of cycle <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Backaches-recurrent <input type="checkbox"/> Joint pain/stiffness <input type="checkbox"/> Leg cramps w/ walking <input type="checkbox"/> Leg cramps at night <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Swelling of joints <input type="checkbox"/> Changes in nails/hair <input type="checkbox"/> Easy bleeding/bruising <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Moles changing/irritated <input type="checkbox"/> Skin rash | | |



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Have you recently had any of the following symptoms/diseases? (Continued)

- | | |
|---|--|
| <input type="checkbox"/> Breast lump/discharge | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Tremor/Hands shaking | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Hayfever/Allergies |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Moodiness-excessive | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Syphills |
| <input type="checkbox"/> During the past month have you been bothered by feeling down, depressed or hopeless? | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> During the past month have you been bothered by little interest or pleasure in doing things? | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Memory loss | |
| <input type="checkbox"/> Phobias | |
| <input type="checkbox"/> Tearfulness | |
| <input type="checkbox"/> Chronic fatigue | |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Increase in thirst | |

I affirm that the information I have given is correct and complete to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my medical status.

Signature _____ Date: ___/___/___

Please list any concerns or physical complaints today:

Medical Conditions/Surgical History/Hospitalizations:

	Date

Drug allergies and Reaction:



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Current Medications and Dosages:

Health Maintenance Update:

Date of most recent:

Breast Exam _____

Mammogram _____

Pap Smear _____

Prostate Exam _____

PSA (Prostate blood test) _____

Stool test for blood _____

Date of most recent:

Flexible Sigmoidoscopy _____

Cholesterol Test _____

Pneumonia Vaccine _____

Tetanus Shot _____

Flu Shot _____

Dilated Eye Exam _____

