Michael Oefelein, M.D.
GemCare Medical Group
Medical History and Intake Form

Today's Date: ___/____/____ Date of Birth: __/____/____

Name:_____ Primary Care Doctor: _____

Pharmacy:_____

Personal Medical History

Please check any of the following problems you have been treated for at any time:

___Acid Refulux (GERD)	___Arthritis	___Asthma	___Pacemaker
___Atrial Fibrillation	___Blood Clots	___COPD/Emphysema	___Defibrillator
___Diverticulitis	___ Depression	___Diabetes	___Heart Stents
___Glaucoma	___Kidney Stones	___Heart Disease	
___Heart Attack	___Heart Valve	___High Cholesterol	
___High Blood Pressure	___Stroke	___Thyroid Problems	

___Cancer (type):_____

Allergies to: Latex: Yes No Medications: _____

Surgical History

Please indicate if you have ever had surgery and when.

None:_____

Urological:

Bladder:	Sling_____	Prolapse_____	Tumor_____	Other_____
Prostate:	Removal_____	TURP_____	Biopsy_____	Other_____
Kidney:	Removal_____	Lithotripsy_____	PERC_____	Other_____
	Ureteroscopy_____			
Radiation:	Organ_____	Radiation Type_____	Date:_____	

Other Surgical History

Mark all that apply, date of surgery or age at time.

Appendectomy_____	Back_____	Knee_____
C-section_____	Open Heart_____	
Tonsillectomy_____	Hernia repair_____	
Hysterectomy_____	Heart Valve_____	

Current Medications

You may bring a copy of medications or medication bottles to appointment if you would like, otherwise list them here.

Medication/Dosage:

1_____ 6_____
2_____ 7_____
3_____ 8_____
4_____ 9_____
5_____ 10_____

Social History

Circle Y (Yes) or N (No) and answer questions completely.

Do you smoke? Y N Cigarettes_____ Cigar_____ Pipe_____ # of years_____

Ever smoked? Y N # per day_____ # of years_____ Year Quit_____

Drink alcohol? Y N Amount_____ Daily: Y N Weekly: Y N Occasionally: Y N

Drink caffeine Y N Coffee_____ Tea_____ # servings per day_____

Do you use illicit drugs? Y N

What is your occupation?_____

Family History

Check any of the following that pertain to blood related family members.

___Kidney Stones ___Diabetes ___Thyroid Disease
___Heart Disease ___Prostate Cancer relationship:_____
___Stroke ___Kidney Cancer relationship:_____
___Lung Problems ___Bladder Cancer relationship:_____

Pregnancy/Birth History

# of Pregnancies_____ # of live Births_____ Last Menstrual Cycle_____

Patient Name:_____
Date of Birth:_____

Review of Systems

Please circle any symptoms you have experienced over the last 30 days.

General
Fever
Chills
Unexplained weight loss
Generalized weakness
Fatigue

Skin
Rash
Itching
Boils

HEENT
Blurred vision
Double vision
Open-angle Glaucoma
Narrow-angle Glaucoma
Sinus Problems

Respiratory
Wheezing
Shortness of breath
Productive Cough

Breast
Breast swelling
Breast tenderness

Cardiovascular
Elevated blood pressure
Chest pain
Irregular heart beat
Swelling of extremities
Heart murmur
Varicose veins

Gastrointestinal
Heartburn/Indigestion
Abdominal pain
Nausea +/- Vomiting
Diarrhea
Constipation

GU Male
Urgency
Frequency
Urinating at night
Difficulty Emptying Bladder
Blood in Urine
Loss of urine control
Slow Stream
Urinary tract infections
Bladder pain
Kidney stones
Difficulty with erections

Musculoskeletal
Arthritis
Back pain
Joint pain
Neck pain

Neurological
Dizziness
Numbness/tingling
Paralysis

Psychological
Anxiety
Depression
Mood Changes

Endocrine
Excessive thirst
Tired/sluggish
Diabetic problems
Decreased sex drive
Thyroid problems

Hematology
Anemia
Blood Clotting problems
Swollen glands

GU Female
Vaginal discharge
Estrogen Supplements

Please list any additional information you would like the physician to know:
_____
_____
_____
_____
_____
_____
_____
_____

Medical Assistant's signature & Date:_____
Physician's Signature & Date:_____

Patient Name:_____
Date of Birth:_____

update: 9/4/2014