My Global Health

30 N Gould St STE R Sheridan, WY 82801 (404) 721-4780

General Medical History Form

Contact Information

(Fill out your information as completely as possible.)

First Name:

Middle Name:

Last Name:

Date of Birth:

Home Phone:

Address:

Address 2:

City:

State:

Zip Code:

Country

Height:

Weight:

Gender:

- ◯ *Female*
- ◯ *Male*

Relationship Status:

Most recent/current occupation:

Tobacco?

- ◯ *Yes*
- ◯ *No*

If yes, how many packs per day? _____

Quit smoking date:

_____

Alcohol?

- ◯ *Yes*
- ◯ *No*

If yes, how many drinks per day?

_____

Quit alcohol date:

_____

Caffeine?

- ◯ *Yes*
- ◯ *No*

If yes, how many drinks per day?

_____

Do you exercise regularly?

_____

Provide your information below:

(Please check conditions currently treated or treated in the past.)

Pulmonary:

- [ ] *Asthma*
- [ ] *OPD or emphysema*
- [ ] *Pneumonia*
- [ ] *Exposure to Tuberculosis*
- [ ] *Sleep Apnea*
- [ ] *Deep vein thrombosis (DVT)*
- [ ] *Pulmonary Hypertension*
- [ ] *Pulmonary Embolism (PE)*

Cardiac:

- [ ] *Hypertension/High blood pressure*
- [ ] *Elevated Cholesterol*
- [ ] *Angina/Chest Pain*
- [ ] *Heart attack*
- [ ] *Irregular heart beat*
- [ ] *Congestive heart failure*
- [ ] *Heart murmur/valve disorder*
- [ ] *Coronary artery disease*

☐ *Pacemaker/Defibrillator*

Vascular:

☐ *Stroke/TIA (transient ischemic attack)*

☐ *Aneurysm*

☐ *Peripheral vascular disease/Poor circulation*

☐ *Vasculitis*

☐ *Varicose veins*

☐ *Hemorrhoids*

Neurological:

☐ *Migraine headache*

☐ *Seizure disorder*

☐ *Muscular Sclerosis*

☐ *Alzheimer's disease*

Liver:

☐ *Hepatitis*

☐ *Gallstones*

☐ *Liver failure (cirrhosis)*

☐ *Chronic Pancreatitis*

Gastrointestinal:

- [ ] *Gastroesophageal reflux disease (heartburn)*
- [ ] *Peptic ulcer disease*
- [ ] *Constipation*
- [ ] *Irritable bowel syndrome*
- [ ] *Inflammatory bowel disease (Crohn's disease, Ulcerative colitis)*

Renal/Urological:

- [ ] *Renal failure*
- [ ] *Interstitial cystitis*
- [ ] *Kidney stones*
- [ ] *Chronic UTI*

Autoimmune:

- [ ] *Osteoarthritis*
- [ ] *Rheumatoid arthritis*
- [ ] *Lupus*
- [ ] *Scleroderma*
- [ ] *Immune deficiency (HIV, AIDS, other)*
- [ ] *Fibromyalgia*

- [ ] *Chronic Fatigue Syndrome*
- [ ] *Sjourgen's Syndrome*

Hematologic:

- [ ] *Anemia*
- [ ] *Bleeding disorder*
- [ ] *Deep vein thrombosis (DVT)*
- [ ] *Pulmonary embolus (PE)*
- [ ] *Other blood disorder (type)*

Oncology:

- [ ] *Cancer (type)*
- [ ] *Cancer treatment*
- [ ] *Chemotherapy*
- [ ] *Radiation*
- [ ] *Surgery*

Metabolic:

- [ ] *Diabetes (Type 1 or Type 2)*
- [ ] *Thyroid disease*
- [ ] *Cushing's disease*

☐ *Addison's disease: Gout*

Muculo-Skeletal:

☐ *Degenerative disc disease*

☐ *Spinal stenosis*

☐ *Sciatica*

☐ *Chronic back pain*

☐ *Hernia*

☐ *Osteoporosis*

Skin/Hair:

☐ *Eczema*

☐ *Psoriasis*

☐ *Hair Loss*

☐ *Other*

Ophthalmologic:

☐ *Glaucoma*

☐ *Cataracts*

☐ *Macular Degeneration*

Psychiatric:

☐ *Depression*

☐ *Anxiety*

☐ *Addiction to drugs or alcohol*

Female Only:

Female Only:

☐ *Menstrual Irregularities*

☐ *Polycystic Ovarian Syndrome*

☐ *Menopause: Urinary Stress Incontinence*

☐ *Breast disease*

☐ *Endometriosis*

Number of pregnancies:

Number of births:

Male Only:

Male Only:

☐ *Benign Prostatic Hypertrophy (BPH)*

☐ *Prostatitis*

☐ *Erectile Dysfunction (ED)*

Family History:

(Please check all disease for which you have a family history (parents/siblings/grandparents)

- [ ] *Heart disease*
- [ ] *High blood pressure*
- [ ] *High cholesterol*
- [ ] *Stroke*
- [ ] *Lung disease*
- [ ] *Cancer*
- [ ] *Arthritis*
- [ ] *Diabetes*
- [ ] *None*
- [ ] *Unknown (adopted)*

Current Medications

(Include over the counter drugs, herbal remedies, and vitamin supplements)

Medication, Dose, How Often?

List of Allergies: (medication/food/environmental)

List all previous surgeries or hospitalizations

(include type of surgery/hospitalization& approximate year)

Surgery(s) List:

Year of Surgery(s):

Have you ever had a reaction to Anesthesia?

Do you have any medical condition that you have been told would disqualify you for any type of medical procedure or surgery?

Do you have special needs that need accommodation? (dietary, sensory, handicap, etc).

Do you have any other medical condition that you are aware of that is not listed above? (If you checked or said yes to any above, please explain.)

Medical Provider

Name of your medical provider:

Provider Contact Phone Number:

Do we have permission to contact?

◯ *Yes*

◯ *No*

Miscellaneous

How did you hear about us?

**Upload an attachment/picture*

Agreement: *By clicking the Submit button, I certify that I have read, understand and agree to the Privacy Policy (/pages/privacy) and Terms of Use (/pages/terms) for* ***My Global Care****. I have the right to submit the above information and agree that it is accurate to the best of my knowledge and that* ***My Global Care*** *and its affiliates are authorized to use it in any way on my behalf to secure health services. I further understand that electronic copy of this Authorization is as equally valid as any original signature or document.*

Printed Name of patient or personal representative