PANACEA O'NEILL MEDICAL GROUP
104 SPENRYN DRIVE
MADISON, AL 35758
(256) 772-4300

Medical History Form

Last Name _____ First _____ Middle _____

Today's Date _____ Date of Birth _____

Please list all known allergies, including drug allergies:

_____ _____ _____

_____ _____ _____

List all medications, with strengths, you are currently taking:

_____ _____ _____

_____ _____ _____

Do you have a family history of any of the following diseases:

Arthritis, Gout _____ Asthma, Hay Fever _____ Cancer _____ Chemical Dependency _____

Diabetes _____ Heart Disease, Strokes _____ High Blood Pressure _____ Kidney Disease _____

Tuberculosis _____ Other _____

Which of the following problems are you currently experiencing:

☐ Decreased Hearing
☐ Ringing in Ear
☐ Ear Infections - Frequent
☐ Dizzy Spells
☐ Failing Vision
☐ Double or Blurred Vision
☐ Eye Pain
☐ Eye Infections - Frequent
☐ Nose Bleeds - Recurrent
☐ Sinus Trouble
☐ Sore Throats - Frequent
☐ Hayfever / Allergies
☐ Hoarseness - Prolonged
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic Cough
☐ Asthma / Wheezing
Shortness of Breath:
☐ On Exertion ☐ Lying Flat
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Palpitations
☐ Irregular Pulse
☐ Swollen Ankles
☐ Fainting Spells

☐ Leg Pain when Walking
☐ Varicose Veins / Phlebitis
☐ Loss of Appetite - Recent
☐ Difficulty Swallowing
☐ Indigestion or Heartburn
☐ Persistent Nausea / Vomiting
☐ Peptic Ulcers
☐ Abdominal Pain - Chronic
☐ Change in Bowel Habits - Recent
☐ Diarrhea ☐ Constipation
☐ Diverticulosis
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Gall Bladder Trouble
☐ Jaundice / Hepatitis
☐ Hernia
☐ Urine Infections - Frequent
☐ Painful Urination
☐ Blood in Urine
☐ Overnight Urination - More than 2
☐ Control in Urination
☐ Decrease in Force of Urination
☐ Kidney Stones
☐ Venereal Disease
☐ Urethral Discharge

☐ Chronic Fatigue
☐ Weight Loss - Recent
☐ Anemia ☐ Bruise Easily
☐ Cancer
☐ Diabetes
☐ Thyroid Disease
☐ Convulsions / Seizures
☐ Stroke
☐ Tremor / Hands Shaking
☐ Muscle Weakness
☐ Numbness / Tingling Sensations
☐ Headaches / Frequent
☐ Arthritis / Rheumatism
☐ Back Pain - Recurrent
☐ Bone Fracture / Joint Injury
☐ Gout
☐ Foot Pain ☐ Cold Numb Feet
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping - Difficulty
☐ Nervousness ☐ Depression
☐ Memory Loss
☐ Moodiness - Excessive
☐ Phobias
☐ Mental Illness

☐ Chicken Pox ☐ Polio
☐ Measles ☐ Germ. Measles
☐ Rheumatic ☐ Scarlet Fever
☐ Mumps ☐ Tuberculosis
☐ Alcohol ☐ oz. per week
☐ Smoking ☐ cig. per day
☐ Coffee / Tea ☐ cups per day

Females - Menstrual History
☐ Age of Onset ____ ☐ Reg. ☐ Irreg.
Flow ☐ Heavy ☐ Mod. ☐ Light
☐ Pain / Cramps with Mens. Flow
☐ Days of flow
☐ Length of Cycle
☐ Pain / Bleeding After Sex
No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages _____
Birth Control Method _____
B.C. Pill (Name) _____
☐ Flushing / Menopause

Other Symptoms or Diseases
☐ _____
☐ _____
☐ _____

List any surgeries (with the dates) you may have had in the past:

_____

_____

Approximate date of your last injection/immunizations: _____

Attestation that all above information is true, correct and up to date:

Patient Signature _____ Date _____

Guardian Signature _____ Date _____