KELLY E. FORDYCE, M.D.

NAME: _____ Health History DATE: _____

Reason(s) for visit	List any current symptoms

Advanced Directive

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Medications – List all medications you take: prescription, non-prescription, and supplements.

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies

☐ No Known Allergies	List other providers you see and reason:

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ Alcoholism		☐ Glaucoma	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis / Liver Disease	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel	
☐ Asthma		☐ Kidney Stones	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Heart Attack	
☐ Blood Clots		☐ Autoimmune Disease	
☐ Cancer (type)		☐ Osteoporosis	
☐ Cerebrovascular Accident (Stroke)		☐ Stomach Ulcer	
☐ Congestive Heart Failure		☐ Renal (Kidney) Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Depression		☐ Thyroid Disease	
☐ Diabetes		☐ Other	
☐ Diverticulitis		☐ Other	

KELLY E. FORDYCE, M.D.

NAME: _____ Health History

Surgical and Hospitalization History			
Surgical Procedure	Year	Hospitalization Reason	Year

Health Maintenance – Enter date of most recent exam/vaccine.			
Exam	Date	Exam	Date
☐ Physical Exam		**Men only:**	
☐ Colonoscopy		☐ PSA/Prostate exam	
☐ EKG			
☐ Cardiac stress test		**Vaccines:**	
☐ Eye exam		☐ Shingles	
Women only:		☐ Covid 19	
☐ Pap/gyn exam		☐ Pneumococcal 23/Prevnar 13	
☐ Mammogram		☐ Influenza (Flu)	
☐ DEXA scan		☐ Tetanus/Tdap	

Family History – Check if any family member has had any of the following and age of death if applicable.

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism							
Alzheimer's Disease							
CAD (Heart Attack)							
Cancer – Type:							
CVA (Stroke)							
Diabetes							
Hyperlipidemia (High cholesterol)							
Hypertension (High blood pressure)							
Mental illness							
Osteoporosis							
Other							

Social History		
Marital Status:	# of Children:	Occupation:
Tobacco Use No Yes	Packs per day: Former/Year quit:	Cigarettes Vape Cigars Chew
Alcohol Use No Yes	Quantity per week: Former/Year quit:	Beer Wine Liquor
Drug Use No Yes	Current Former Year Quit:	Type:
Sexually Active No Yes	Men Women	Method of Contraception: