WILLIS
Senior Housecalls

Phone: (214) 491-4191 | Fax: (469) 519-0407
WillisSeniorHousecalls.com

MEDICAL HISTORY

_____

Patient Name

PLEASE CHECK ALL THAT APPLY

☐ Anxiety	☐ Arthritis/Rheumatism	☐ Asthma
☐ Blood Clots	☐ Cirrhosis	☐ COPD
☐ Depression	☐ Diabetes	☐ Eczema
☐ Acid Reflux	☐ GERD	☐ Gout
☐ Hearing/Vision Issues	☐ Heart Attack	☐ High Blood Pressure
☐ High Cholesterol	☐ Osteoporosis	☐ Psoriasis
☐ Stroke	☐ Thyroid Disease	☐ Ulcer
☐ Heart Problems:	☐ Cancer:	☐ Other:
_____	_____	_____

PAST SURGICAL HISTORY

Procedure: Date:

_____ _____ Colonoscopy: (Yes/No) Date: _____

_____ _____ Mammogram: (Yes/No) Date: _____

_____ _____ PAP Smear: (Yes/No) Date: _____

_____ _____

SOCIAL HISTORY

Type:

Tobacco: (Yes/No) _____ Cigarettes: (Yes/No) ____ packs/day ____ years

Alcohol: (Yes/No) _____ Amount/Frequency: _____

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Caffeine: (Yes/No) _____ Amount/Frequency: _____

Drugs: (Yes/No) _____ Amount/Frequency: _____

Exercise: (Yes/No) Frequency: _____ Diet: (Yes/No) _____

ALLERGIES

Medication or Substance:	Describe Reaction or Symptom:
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS

Name:	Amount/Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HERBAL, VITAMIN OR NUTRITIONAL THERAPIES

Name:	Amount/Frequency:
_____	_____
_____	_____
_____	_____

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FAMILY HISTORY

	Father	Mother	Siblings
Deceased	☐	☐	☐
Alcoholism	☐	☐	☐
Asthma	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Failure	☐	☐	☐
High Blood Pressure	☐	☐	☐
Mental Illness	☐	☐	☐
Osteoporosis	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Disease	☐	☐	☐
Other:	☐	☐	☐