MAGNOLIA
PREMIER HEALTH
CONCIERGE MEDICINE
JAMIE CAUDILL, M.D.
LYN DIEFENDERFER, M.D.

MEDICAL HISTORY

Past Medical History:

- ❑ Hypertension/High Blood Pressure
- ❑ Diabetes Mellitus
- ❑ Heart Disease
- ❑ Asthma/COPD
- ❑ Atrial Fibrillation
- ❑ TIA/Stroke
- ❑ Thyroid Disease
- ❑ GERD/Peptic Ulcer Disease
- ❑ Liver Disease/Hepatitis/Cirrhosis
- ❑ HIV/AIDS
- ❑ Anxiety
- ❑ DEPRESSION

❑ Cancer (Type & When Diagnosed):_____

Please Specify Any Other Medical Conditions:

_____

_____

_____

_____

_____

Past Surgical History:

- ❑ Appendectomy
- ❑ Cholecystectomy
- ❑ Hysterectomy
- ❑ Tonsillectomy
- ❑ CABG
- ❑ Gastric Sleeve/Gastric Bypass
- ❑ Thyroidectomy
- ❑ Heart Valve Replacement (Please Specify):_____
- ❑ Carotid Artery
- ❑ Amputation (Please Specify):_____
- ❑ Orthopedic Surgery (Please Specify): _____

Please Specify Any Other Surgical Procedures:

_____

_____

_____

_____

_____

Allergies (Please Specify Reaction):

_____

_____

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Social History:

Do You Smoke? ❑Yes ❑No How Long?_____ How Much?_____

Have You Ever Smoked? ❑Yes ❑No When Did You Quit? _____

Do You Drink Alcohol? ❑Yes ❑No How Much Per Week?_____

Do You Sleep Regularly? ❑Yes ❑No

Do You Have Regular Exercise Habits? ❑Yes ❑No

Do You Eat Well-Balanced Meals? ❑Yes ❑No

Have You Ever Used Street Drugs? If So, Please Specify:_____

Family History:

Is Your Mother Living? ❑Yes ❑No Died At Age:_____ Cause:_____

Is Your Father Living? ❑Yes ❑No Died At Age:_____ Cause:_____

Brothers Living? ❑Yes ❑No Died At Age:_____ Cause:_____

Sisters Living? ❑Yes ❑No Died At Age:_____ Cause:_____

Does Anyone In Your Immediate Family Have Heart Disease, Diabetes, Cancer, Or Any Other Chronic Illness?

_____

Health Maintenance:

Do You Take Aspirin? ❑Yes ❑No

Have You Had A Colonoscopy? ❑Yes ❑No When?_____

Have You Had A Mammogram? ❑Yes ❑No When?_____

Have You Had A Breast Exam? ❑Yes ❑No When?_____

Have You Had A PSA (If Male)? ❑Yes ❑No When?_____

Have You Had A Pneumonia Vaccine? ❑Yes ❑No When?_____

Have You Had A COVID-19 Vaccine? ❑Yes ❑No When?_____

Date of Last Gynecological Exam/Pap Smear:_____

DO YOU HAVE AN ADVANCE DIRECTIVE OR SIGNED DNR? ❑Yes ❑No

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CURRENT MEDICATIONS/SUPPLEMENTS

Name of Medication	Strength	Frequency

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PHYSICIAN SERVICES & TESTING

Please List The Names Of Your Other Physicians:

SPECIALTY	PHYSICIAN NAME	SPECIALTY	PHYSICIAN NAME
ALLERGY/IMMUNOLOGY		OPHTHALMOLOGY	
CARDIOLOGY		ORTHOPEDICS	
DERMATOLOGY		OTOLARYNGOLOGY (ENT)	
GASTROENTEROLOGY		PAIN MANAGEMENT	
GYNECOLOGY		PODIATRY	
HEMATOLOGY		PULMONOLOGY	
NEUROLOGY		PSYCHIATRY	
NEPHROLOGY		RHEUMATOLOGY	
ONCOLOGY		UROLOGY	

Please List The Most Recent Date You Had Any Of These Tests/Services:

NAME	DATE	NAME	DATE
Abdominal Ultrasound		Hemoccult Stool Cards	
Annual Physical Exam		Mammogram	
Bone Density Scan		Mini-Mental Status Exam	
Cardiac Catheterization		Neuropsychological Testing	
Carotid Ultrasound		Pap Smear	
Chest X-Ray		PSA	
Colonoscopy		Spirometry Test	
CT Scan		Stress Test	
Echocardiogram		TB Skin Test	
EEG		Upper Endoscopy	
EKG		Vision/Hearing Test	

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REVIEW OF SYSTEMS

Please Check Any Symptoms That You Are Experiencing:

GENERAL:
Weight Loss ❑
Weight Gain ❑
Night Sweats ❑
Insomnia ❑
Fatigue ❑

ENDOCRINE:
Excessive Thirst ❑
Excessive Hair ❑
Hair Loss ❑
Hot Flashes ❑
Always Hot ❑
Always Cold ❑
Erectile Dysfunction ❑
Infertility ❑
Decreased Libido ❑
Pain During Sexual Intercourse ❑

GYNECOLOGICAL:
Menopause ❑
Irregular Periods ❑
Breast Tenderness ❑
Breast Lumps ❑
Vaginal Irritation ❑
Vaginal Discharge ❑
Vaginal Dryness ❑

CARDIOVASCULAR:
Chest pain ❑
Palpitations ❑
Ankle Swelling ❑
Calf Pain ❑
Varicose Veins ❑

UROLOGICAL:
Painful Urination ❑
Recurrent Infections ❑
Frequent Urination ❑
Blood In Urine ❑
Incontinence ❑
Slow Urine Flow ❑
Dribbling ❑

RESPIRATORY:
Cough ❑
Coughing Up Blood ❑
Wheezing ❑
Shortness of Breath ❑
Sputum Production ❑

NEUROLOGICAL:
Double Vision ❑
Headache ❑
Dizziness ❑
Fainting ❑
Weakness ❑
Numbness ❑
Tingling ❑
Ringing In Ears ❑
Tremors ❑

GASTROINTESTINAL:
Difficulty Swallowing ❑
Heartburn/Reflux ❑
Nausea/Vomiting ❑
Diarrhea ❑
Constipation ❑
Bloody/Black Stools ❑
Abdominal Pain ❑
Jaundice ❑

EYES:
Blurry Vision ❑
F lashing Lights ❑
Itchy Eyes ❑
Dry Eyes ❑

DERMATOLOGIC:
Suspicious Moles ❑
Skin Rashes ❑
Skin Ulcers ❑
Acne ❑
Skin Discloration ❑

ORTHOPEDIC:
Joint Pain ❑
Joint Swelling ❑
Back Pain ❑
Neck Pain ❑

PSYCHOLOGICAL:
Depression ❑
Anxiety ❑
Memory Loss ❑
Hallucinations ❑
Suicidal Thoughts ❑
Mood Changes ❑

ENT:
Deafness ❑
Nose Bleeds ❑
Runny Nose ❑
Sneezing ❑
Hoarseness ❑
Sore Throat ❑

Please List Your 5 Personal Health Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

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DIETARY / LIFESTYLE

NUTRITION SURVEY:

How Would You Rate Your Diet In General? ❑ Healthy ❑ Moderately Healthy ❑ Poor

On Average, What Is The Total Number Of Servings Of Fruits & Vegetables That You Have Each Day? _____

On Average, How Much Water Do You Drink Each Day? _____

On Average, How Much Coffee/Tea Do You Drink Each Day? _____

On Average, How Many Sodas Do You Drink Each Week?_____

Do You Drink Diet Soda or Use Artificial Sweeteners? _____

Do You Have Any Food Allergies or Food Intolerances?_____

Please Describe Any Unhealthy Aspects of Your Diet:

_____

_____

_____

_____

Please List Any Improvements You Would Like To Make:

_____

_____

_____

_____

EXERCISE SURVEY:

Please Describe Your Exercise Habits:

Type of Exercise_____

Frequency of Exercise_____

Other Types of Physical Activity_____

Goals For Exercise This Year_____

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SLEEP SURVEY:

Please Check The Condition Which Describes How Your Sleep Is Now Or How It Has Changed This Year:

- ❑ I Have No Difficulty Falling Asleep Or Staying Asleep
- ❑ I Awaken Frequently During The Night
- ❑ I Have Difficulty Getting Up In The Morning
- ❑ I Have Difficulty Falling Asleep At Night
- ❑ Problems With Snoring
- ❑ I Have Problems With Sleep Walking
- ❑ I Require Frequent Naps To Function
- ❑ I Have Been Previously Diagnosed or Suspect That I Have Sleep Apnea
- ❑ I Feel That I Sleep Too Much
- ❑ I Am Sleepy Throughout The Day
- ❑ I Use Sleep Aids/Medications To Help Me Sleep At Night

STRESS SURVEY:

Any Changes In Marital Status?_____

Any Marital/Relationship Concerns? _____

Any Changes In Work? _____

Any New Children or Grandchildren? _____

Any Recent Moves? _____

Any Major Financial Changes? _____

Any Recent Weight Changes? _____

Any Recent Personal or Family Illness? _____

Are You Primary Caregiver For A Family Member/Friend?_____

Any New Hobbies? _____

Do You Receive Counseling or Therapy? _____

Have You Ever Been Admitted To A Mental Health Facility?

_____

_____