Date Received: _____

Wiscasset Family Medicine

Cortney Linville, DO
Edward B. Kitfield, MD
Sarah L. Hurley, PA-C
Mary S. Rafter, FNP
Sarah H. Robey, PA-C

Patient Medical History Form

Name: _____ Age: _____ Date of Birth_____/_____/_____

PHYSICIAN you were seeing previously: _____

Other **SPECIALISTS** you currently see:

_____

_____

CURRENT Medical Concerns

_____

_____

_____

List all **CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATIONS** (include dosage, reason you take it, who prescribed it, use last page for more room if you need to)

_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)

List all ALLERGIES (include food, environmental, & medication allergies)

_____

_____

_____

_____

Wiscasset Family Medicine

Cortney Linville, DO
Sarah L. Hurley, PA-C
Mary S. Rafter, FNP
Edward B. Kitfield, MD
Sarah H. Robey, PA-C

List all SURGERIES you have had (include year, surgeon, and hospital)

_____

_____

Describe **HOSPITALIZTIONS/ILLNESSES** do not include above (Include year, hospital)

_____

_____

MEDICAL HISTORY

Have you had (check all that apply):

☐ migraines	☐ hepatitis	☐ mono	☐ ulcer	☐ bleeding problem
☐ blood clots	☐ head injury	☐ drug addiction	☐ gallstones	☐ tuberculosis
☐ STDs	☐ seizures	☐ memory trouble	☐ arthritis	☐ shingles
☐ psoriasis	☐ heart murmur	☐ rheumatic fever	☐ polio	☐ gout
☐ alcoholism	☐ drug abuse	☐ depression	☐ mental illness	☐ hemorrhoids
☐ hearing trouble	☐ vision trouble	☐ other(s): _____		

Do you have a Living Will? ☐ Yes ☐ No **If not, are you interested in having one?** ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

(please list family medical problems, including substance abuse or mental health concerns or cause of death)

Mother: _____
Father: _____
Siblings: _____

Please list pertinent diseases that run in your family and specify your relationship to each family member listed.

_____

_____

_____

Wiscasset Family Medicine

Cortney Linville, DO
Sarah L. Hurley, PA-C
Mary S. Rafter, FNP
Edward B. Kitfield, MD
Sarah H. Robey, PA-C

WOMEN'S MEDICAL HISTORY

Birth control method _____

Date of last Pap _____/_____/_____ Result_____ Done where? _____

Date of last mammogram ____/____/_____ Result _____ Done where? _____

Anything else you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ADDITIONAL PRESCRIPTIONS

(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)