**Medical History Form**

# Directions: Please answer the following questions to the best of your knowledge.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | |
| **Last Name** | **First Name** | **Middle** | | **Primary Language** | **Social Security No.** | |
| **Street Address** | **City** | **State Zip** | | **OK to Send Letter?**   Yes  No | **Sex:**   Male  Female | |
| **Home Phone** | **OK to Call?**   Yes  No | **Work Phone** | | **OK to Call?**   Yes  No | **If No, How can you be reached?** | |
| **Date of Birth** | **Marital Status:**  Single without partner Single with partner Length of Time:   Married  Separated  Divorced  Widowed | | | | | |
| **Sexual Orientation**  Heterosexual  Homosexual  Bisexual | | | |  | |  |
| **Children:**  Yes  No How Many? | | | **Number of Persons Living in Your Home?** | | | **Race/ Ethnicity** |
| **Emergency Contact Person** | | **Phone Number** | | **Relationship** | |  |

|  |  |  |
| --- | --- | --- |
| **PRIMARY PHYSICIAN(S)** |  |  |
| Name | Name | Name |
| Address | Address | Address |
|  |  |  |
|  |  |  |
|  |  |  |
| Phone: | Phone: | Phone: |

Medication Allergies? ◻ Yes ◻ No Substance or Food Allergies? ◻ Yes ◻ No

If yes, what medication(s) If yes, what substance(s)

**FAMILY HISTORY: Please check the box if your family has a history of:**

* Diabetes ◻ High Blood Pressure ◻ Heart Attack, Heart Disease ◻ Blood Clots or Stroke ◻ Tuberculosis
* Cancer ◻ Alzheimer’s ◻ Family History Unknown ◻ Mental Illness ◻ Epilepsy/Seizure

Any other major conditions?

If you answered Yes to any of the above, please explain:

Are you currently being treated for medical conditions? ◻ Yes ◻ No if yes, please list:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MEDICATIONS (List more on separate page if necessary)** | | | | | |
| **Current Medications** | **For what condition?** | **Dosage** | **Frequency** | **Date started** | **Comments / Problems / Concerns** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc)** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| **Social/Sexual Risk History** | |
| * Yes ◻ No | Do you smoke? If yes, how many cigarettes per day? |
| * Yes ◻ No | Do you use alcohol? If yes, how often, how much? |
| * Yes ◻ No | Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain) |
| * Yes ◻ No | Have you ever had or would you like help now with an alcohol or drug problem? |
| * Yes ◻ No | Would you like to discuss problems related to a rape or emotional/physical/sexual abuse? |
| * Yes ◻ No | Are you now or have you ever been in a relationship where you have been physically hurt or threatened? |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following** | | | | |
|  |  |  |  |  |
| **1. General** |  |  |  |  |
| Productive cough (3 weeks or more) | * Current ◻ Past |  | Unusual discharge (vaginal or from penis) | * Current ◻ Past |
| Dry, unproductive cough (3 wks or more) | * Current ◻ Past |  | Bloody or painful urination | * Current ◻ Past |
| Shortness of breath | * Current ◻ Past |  | Dark, bloody or painful bowel movements | * Current ◻ Past |
| Chest pain | * Current ◻ Past |  | Hepatitis A | * Current ◻ Past |
| Recurrent night sweats, chills, fevers | * Current ◻ Past |  | Hepatitis B | * Current ◻ Past |
| Swollen glands (neck, armpits or groin) | * Current ◻ Past |  | Hepatitis C | * Current ◻ Past |
| Persistent weight loss without dieting | * Current ◻ Past |  | Chronic Fatigue | * Current ◻ Past |
| Weight problem/eating disorder | * Current ◻ Past |  | Cancer | * Current ◻ Past |
|  |  |  |  |  |
| Tuberculosis: Ever Tested? ◻ Yes ◻ No Date and result of last test: If Positive, did you have a chest x-ray? | | | | |
| Ever Treated? ◻ Yes ◻ No Date(s) and type(s) of treatment: | | | | |
|  | | | | |
| HIV: Ever Tested? ◻ Yes ◻ No Would you like information regarding HIV/AIDS or testing sites? ◻ Yes ◻ No | | | | |
|  | | | | |
| **REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following:** | | | | |
|  |  |  |  |  |
| **2. Skin** |  |  | **7. Gastrointestinal** |  |
| Allergies/Rash/Itching | * Current ◻ Past |  | Recurrent nausea/vomiting/diarrhea | * Current ◻ Past |
| Psoriasis / Eczema | * Current ◻ Past |  | Stomach/bowel problems | * Current ◻ Past |
|  |  |  | Gall bladder disease | * Current ◻ Past |
| **3. Eyes** |  |  | Pancreatitis | * Current ◻ Past |
| Vision problems | * Current ◻ Past |  | Diabetes / hyperglycemia / hypoglycemia | * Current ◻ Past |
| Eye infections | * Current ◻ Past |  | Encopresis (incontinent of feces) | * Current ◻ Past |
|  |  |  |  |  |
| **4. Ears, Nose, Throat, Lungs** |  |  | **8. Genitourinary** |  |
| Hearing problems | * Current ◻ Past |  | Bladder/kidney problems or infection | * Current ◻ Past |
| Teeth/gum problems or disease | * Current ◻ Past |  | Incontinence (unable to control bladder) | * Current ◻ Past |
| Frequent nosebleeds | * Current ◻ Past |  | Enuresis (bedwetting) | * Current ◻ Past |
| Recurrent sinusitis | * Current ◻ Past |  | Sexually transmitted diseases: |  |
| Frequent sore throats | * Current ◻ Past |  | Gonorrhea Syphilis Herpes |  |
| Recurrent Pneumonia | * Current ◻ Past |  | Chlamydia Trichomonas |  |
| Asthma | * Current ◻ Past |  | HPV or genital warts |  |
|  |  |  |  |  |
| **5. Cardiac** |  |  | **Females:** |  |
| Palpitations/arrhythmia | * Current ◻ Past |  | Menstrual Difficulties | * Current ◻ Past |
| Heart disease/murmur | * Current ◻ Past |  | Cycle: Regular Irregular |  |
| High blood pressure / Low blood pressure | * Current ◻ Past |  | Pre-Menopause Menopause |  |
| High cholesterol | * Current ◻ Past |  | Problems/infection of tubes/ovaries/uterus | * Current ◻ Past |
| Thrombophlebitis/blood clots | * Current ◻ Past |  | Abnormal Pap Smear(s) | * Current ◻ Past |
|  |  |  | Number of pregnancies |  |
| **6. Neurological** |  |  | Number of births |  |
| Stroke | * Current ◻ Past |  | Problems with pregnancies/births (explain) |  |
| Frequent Headaches or Migraines | * Current ◻ Past |  |  |  |
| Seizures/Epilepsy | * Current ◻ Past |  | Breast disease / tumor / surgery (explain) |  |
| Weakness/paralysis/unsteady walking | * Current ◻ Past |  |  |  |
| Dizziness/confusion/wandering | * Current ◻ Past |  | **Miscellaneous:** |  |
| Forgetfulness/memory lapse/memory loss | * Current ◻ Past |  | Anemia / blood disorder | * Current ◻ Past |
|  |  |  | Arthritis | * Current ◻ Past |
| **Other conditions / problems not listed:** |  |  | Sleep disturbance | * Current ◻ Past |

# I certify that I have answered these questions to the best of my knowledge

Patient Signature: Date:

**CLINICIANS NOTES (CLARIFICATIONS / FOLLOW UP / ETC)**

Reviewed by (Clinician):

Date: