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
If yes, what medication(s) _____

Substance or Food Allergies? ☐ Yes ☐ No
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?

Patient Name: _____

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:

Patient Name: _____