

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	Marital Status: <input type="checkbox"/> Single without partner <input type="checkbox"/> Single with partner Length of Time: _____ <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Sexual Orientation	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual			
Children: <input type="checkbox"/> Yes <input type="checkbox"/> 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:
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- | | | | | |
|-----------------------------------|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack, Heart Disease | <input type="checkbox"/> Blood Clots or Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Family History Unknown | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> 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)					
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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)			
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Social/Sexual Risk History	
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many cigarettes per day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use alcohol? If yes, how often, how much?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had or would you like help now with an alcohol or drug problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Current <input type="checkbox"/> Past		Unusual discharge (vaginal or from penis) <input type="checkbox"/> Current <input type="checkbox"/> Past
Dry, unproductive cough (3 wks or more)	<input type="checkbox"/> Current <input type="checkbox"/> Past		Bloody or painful urination <input type="checkbox"/> Current <input type="checkbox"/> Past
Shortness of breath	<input type="checkbox"/> Current <input type="checkbox"/> Past		Dark, bloody or painful bowel movements <input type="checkbox"/> Current <input type="checkbox"/> Past
Chest pain	<input type="checkbox"/> Current <input type="checkbox"/> Past		Hepatitis A <input type="checkbox"/> Current <input type="checkbox"/> Past
Recurrent night sweats, chills, fevers	<input type="checkbox"/> Current <input type="checkbox"/> Past		Hepatitis B <input type="checkbox"/> Current <input type="checkbox"/> Past
Swollen glands (neck, armpits or groin)	<input type="checkbox"/> Current <input type="checkbox"/> Past		Hepatitis C <input type="checkbox"/> Current <input type="checkbox"/> Past
Persistent weight loss without dieting	<input type="checkbox"/> Current <input type="checkbox"/> Past		Chronic Fatigue <input type="checkbox"/> Current <input type="checkbox"/> Past
Weight problem/eating disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past		Cancer <input type="checkbox"/> Current <input type="checkbox"/> Past
Tuberculosis: Ever Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date and result of last test: _____ If Positive, did you have a chest x-ray? _____			
Ever Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s) and type(s) of treatment: _____			
HIV: Ever Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like information regarding HIV/AIDS or testing sites? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Current <input type="checkbox"/> Past	Recurrent nausea/vomiting/diarrhea	<input type="checkbox"/> Current <input type="checkbox"/> Past
Psoriasis / Eczema	<input type="checkbox"/> Current <input type="checkbox"/> Past	Stomach/bowel problems	<input type="checkbox"/> Current <input type="checkbox"/> Past
		Gall bladder disease	<input type="checkbox"/> Current <input type="checkbox"/> Past
3. Eyes		Pancreatitis	<input type="checkbox"/> Current <input type="checkbox"/> Past
Vision problems	<input type="checkbox"/> Current <input type="checkbox"/> Past	Diabetes / hyperglycemia / hypoglycemia	<input type="checkbox"/> Current <input type="checkbox"/> Past
Eye infections	<input type="checkbox"/> Current <input type="checkbox"/> Past	Encopresis (incontinent of feces)	<input type="checkbox"/> Current <input type="checkbox"/> Past
4. Ears, Nose, Throat, Lungs		8. Genitourinary	
Hearing problems	<input type="checkbox"/> Current <input type="checkbox"/> Past	Bladder/kidney problems or infection	<input type="checkbox"/> Current <input type="checkbox"/> Past
Teeth/gum problems or disease	<input type="checkbox"/> Current <input type="checkbox"/> Past	Incontinence (unable to control bladder)	<input type="checkbox"/> Current <input type="checkbox"/> Past
Frequent nosebleeds	<input type="checkbox"/> Current <input type="checkbox"/> Past	Enuresis (bedwetting)	<input type="checkbox"/> Current <input type="checkbox"/> Past
Recurrent sinusitis	<input type="checkbox"/> Current <input type="checkbox"/> Past	Sexually transmitted diseases:	
Frequent sore throats	<input type="checkbox"/> Current <input type="checkbox"/> Past	___ Gonorrhea ___ Syphilis ___ Herpes	
Recurrent Pneumonia	<input type="checkbox"/> Current <input type="checkbox"/> Past	___ Chlamydia ___ Trichomonas	
Asthma	<input type="checkbox"/> Current <input type="checkbox"/> Past	___ HPV or genital warts	
5. Cardiac		Females:	
Palpitations/arrhythmia	<input type="checkbox"/> Current <input type="checkbox"/> Past	Menstrual Difficulties	<input type="checkbox"/> Current <input type="checkbox"/> Past
Heart disease/murmur	<input type="checkbox"/> Current <input type="checkbox"/> Past	Cycle: Regular ___ Irregular ___	
High blood pressure / Low blood pressure	<input type="checkbox"/> Current <input type="checkbox"/> Past	Pre-Menopause ___ Menopause ___	
High cholesterol	<input type="checkbox"/> Current <input type="checkbox"/> Past	Problems/infection of tubes/ovaries/uterus	<input type="checkbox"/> Current <input type="checkbox"/> Past
Thrombophlebitis/blood clots	<input type="checkbox"/> Current <input type="checkbox"/> Past	Abnormal Pap Smear(s)	<input type="checkbox"/> Current <input type="checkbox"/> Past
		Number of pregnancies _____	
6. Neurological		Number of births _____	
Stroke	<input type="checkbox"/> Current <input type="checkbox"/> Past	Problems with pregnancies/births (explain)	
Frequent Headaches or Migraines	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Seizures/Epilepsy	<input type="checkbox"/> Current <input type="checkbox"/> Past	Breast disease / tumor / surgery (explain)	
Weakness/paralysis/unsteady walking	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Dizziness/confusion/wandering	<input type="checkbox"/> Current <input type="checkbox"/> Past	Miscellaneous:	
Forgetfulness/memory lapse/memory loss	<input type="checkbox"/> Current <input type="checkbox"/> Past	Anemia / blood disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past
		Arthritis	<input type="checkbox"/> Current <input type="checkbox"/> Past
Other conditions / problems not listed:		Sleep disturbance	<input type="checkbox"/> Current <input type="checkbox"/> 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: _____
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Patient Name: _____