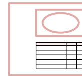


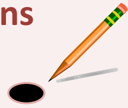
MRN#

Update Medical History
Age 13 and older

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please complete this history form. This will allow us to serve your health needs.
The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

SOCIAL HISTORY

TOBACCO USE

What is your smoking status? — current (every day) ◯ previous ◯ current (some days) ◯ never ◯

How many packs per day do you (or did you) smoke? — less than 1 ◯ 1-2 ◯ more than 2 ◯

How many years have you (or did you) smoke? — less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

Do you use other tobacco products? — currently ◯ in the past ◯ never ◯

ALCOHOL USE

Do you consume alcohol? — currently ◯ in the past ◯ never ◯

Average number of drinks per week (now or in the past)? — 7 or less ◯ 8-14 ◯ 15+ ◯

OTHER

IV drug use or other recreational drug use? — currently ◯ in the past ◯ never ◯

Have you engaged in high risk behavior for sexually transmitted diseases?
(anal sex, homosexual activity, multiple sex partners) — currently ◯ in the past ◯ never ◯

Are you sexually active? — yes ◯ no ◯

Have you ever had a blood transfusion? — yes ◯ no ◯

Do you see a dentist regularly? — yes ◯ no ◯

How often do you exercise? (times per week) — never ◯ 1-2 ◯ 5-6 ◯ occasionally ◯ 3-4 ◯ 7 ◯

SURGICAL HISTORY

Please mark all surgeries you have had in the past year:

◯ **I HAVE NEVER HAD SURGERY** ◯ **I HAVE NOT HAD SURGERY IN THE LAST YEAR**

◯ Appendectomy
◯ Breast Augmentation
◯ Breast Lumpectomy
◯ Breast Reduction
◯ Cataract Surgery
◯ Colostomy
◯ Coronary Artery Bypass
◯ Gallbladder Surgery
◯ Hysterectomy (due to cancer)
◯ Hysterectomy (not due to cancer)
◯ Mastectomy
◯ Ovary Removal
◯ Prostate Surgery
◯ Tubal Ligation
◯ Vasectomy

Caesarean Section 1 ◯ 2 ◯ 3 or more ◯

Other Surgery (please specify): ____________________

YOUR MEDICAL HISTORY

Please indicate if YOU have had a new diagnosed disease or illness within the past year.
Mark all that apply. If none mark "**NO MEDICAL HISTORY**."

PAST	CURRENT	
◯	◯	Abnormal Pap Smear
◯	◯	Anemia
◯	◯	Blood Clots
◯	◯	Breast Cancer
◯	◯	Cervical Cancer
◯	◯	Colon Cancer
◯	◯	Congestive Heart Failure
◯	◯	COPD / Emphysema
◯	◯	Coronary Artery Disease
◯	◯	Diabetes Type 2
◯	◯	Heart Attack

PAST	CURRENT	
◯	◯	High Blood Pressure
◯	◯	High Cholesterol
◯	◯	Hypothyroid (Low Thyroid)
◯	◯	Liver Cancer
◯	◯	Lung Cancer
◯	◯	Melanoma (Skin)
◯	◯	Osteoporosis
◯	◯	Prostate Cancer
◯	◯	Sexually Transmitted Disease (STD)
◯	◯	Sleep Apnea
◯	◯	Stroke / CVA of the Brain
	◯	**NO MEDICAL HISTORY**

Other Disease, Cancer or Significant Medical Illness (please specify): ____________________

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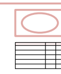
SAMPLE

MRN#

Update Medical History
Age 13 and older



STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a new diagnosis this year:

FAMILY HISTORY UNKNOWN ◯ ADOPTED ◯ NO FAMILY MEDICAL HISTORY ◯

	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Breast Cancer (Before 50)	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer (After 50)	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer (Before 50)	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer (After 50)	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes Type 2 (Adult)	◯	◯	◯	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯	◯	◯
Hypothyroid (Low Thyroid)	◯	◯	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯	◯	◯
Prostate Cancer	◯	◯	◯	◯	◯	◯	◯	◯

◯ Mother, Grandmother, or Sister developed Heart Disease before the age of 65.

◯ Father, Grandfather, or Brother developed Heart Disease before the age of 55.

PREVENTATIVE HEALTH

WOMEN ONLY

	n/a	under 8	8	9	10	11	12	13	14	15	16	17	18	19	20	21+
Age at onset of menstruation:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

	n/a	under 42	42	43	44	45	46	47	48	49	50	51	52	53	54	55+
Age at onset of menopause:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

PREGNANCY HISTORY	0	1	2	3	4	5	6	7+
Number of pregnancies:	◯	◯	◯	◯	◯	◯	◯	◯
Number born alive:	◯	◯	◯	◯	◯	◯	◯	◯
Number of premature births:	◯	◯	◯	◯	◯	◯	◯	◯
Number of miscarriages:	◯	◯	◯	◯	◯	◯	◯	◯
Number of abortions:	◯	◯	◯	◯	◯	◯	◯	◯

Please write in the start date of your last menstrual period (include month / day / year): ____________________

Are you pregnant or possibly pregnant? yes ◯ no ◯ n/a ◯

Have you had any problems with sexual activity? yes ◯ no ◯ n/a ◯

Are you currently using birth control?
yes ◯ no ◯ n/a ◯ If yes, what method? ____________________

BOTH MEN AND WOMEN

Please list ANY immunizations you've received outside of this office in the last year. Include approximate date.

____

Please indicate when you last had each of the applicable tests:

	N/A	1 year or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10+ years ago	RESULTS: Normal	Abnormal	Don't Know
Mammogram	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Colonoscopy	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pap Smear	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bone Density / Dexa Scan	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Prostate Cancer Screening	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Stool Hemocult (blood in stool)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Eye Exam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

MEN ONLY

Any problems with erectile dysfunction? yes ◯ no ◯ n/a ◯

OTHER

****Please review your medication list with the nurse and make corrections if needed.****

Please list any new allergies we should know about: ____________________

Please list any other physicians you have seen in the last year, so that we can obtain your records:

____

Please list any hospital admissions / emergency room visits you have had in the last year. List the reason(s).

____

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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SAMPLE