Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient Medical History
Age 13 and older

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

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

Marking Instructions

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

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) ◯ current (some days) ◯ previous ◯ 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+ ◯
Does anyone in your household smoke? yes ◯ no ◯
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 or more ◯

OTHER

Do you live alone? yes ◯ no ◯
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 ◯
Do you have any tattoos? yes ◯ no ◯
Do you have working smoke detectors in your home? yes ◯ no ◯
How often do you exercise? (times per week)
occasionally ◯ 0 ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7 ◯
Do you always wear seat belts? yes ◯ no ◯
Do you have guns in your home? yes ◯ no ◯

SURGICAL HISTORY

Please mark all surgeries you have had.

◯ **I HAVE HAD NO SURGERIES**
◯ Appendectomy
◯ Breast Augmentation
◯ Breast Lumpectomy
◯ Breast Reduction
◯ Carotid Artery Surgery
◯ Cataract Surgery
◯ Colostomy
◯ Foot Surgery
◯ Gallbladder Surgery
◯ Heart Bypass Surgery
◯ Hysterectomy (due to cancer)
◯ Hysterectomy (not due to cancer)
◯ Inguinal Hernia Surgery
◯ Kidney Removal
◯ Knee Surgery
◯ Low Back Disc Surgery
◯ Lung Surgery
◯ Mastectomy
◯ Neck Disc Surgery
◯ Ovary Removal
◯ Pacemaker
◯ Prostate Surgery
◯ Shoulder Surgery
◯ Sinus Surgery
◯ Thyroid Removal
◯ Tonsillectomy
◯ Total Hip Replacement
◯ Total Knee Replacement
◯ Tubal Ligation
◯ Vasectomy
◯ Weight Loss Surgery

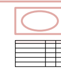
Caesarean Section 1 ◯ 2 ◯ 3 or more ◯
Heart Valve Replacement mitral ◯ aortic ◯ tricuspid ◯ unknown valve ◯

Other Surgery (please specify): ____________________

Copyright © PatientLink Card 248 (Rev. 02/15/2012)
SAMPLE

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient Medical History
Age 13 and older


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

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following.
Mark all that apply. If none, mark, "**NO MEDICAL HISTORY**."

PAST	CURRENT	
		Abnormal Pap Smear
		Alcohol Abuse
		Allergies / Sinus
		Alzheimers
		Anemia
		Anxiety
		Arthritis
		Asthma
		Birth Defects
		Bleeding Disease
		Blindness
		Blood Clots
		Breast Cancer
		Bipolar Disorder
		Cataracts
		Cervical Cancer
		Colon Cancer
		Congestive Heart Failure
		COPD / Emphysema
		Coronary Artery Disease
		Crohn's Disease
		Depression
		Diabetes Type 1
		Diabetes Type 2
		Glaucoma
		Gout
		Hearing Loss
		Heart Attack
		Hepatitis B
		Hepatitis C

PAST	CURRENT	
		High Blood Pressure
		High Cholesterol
		HIV /AIDS
		Hypothyroid (Low Thyroid)
		Irritable Bowel Disease
		Kidney Stones
		Liver Cancer
		Lung Cancer
		Lupus
		Melanoma (Skin)
		Migraines
		Multiple Sclerosis
		Osteoporosis
		Parkinson's Disease
		Prostate Cancer
		Prostate Problems
		Paraplegia
		Quadraplegia
		Reflux / GERD
		Rheumatic Fever
		Rheumatoid Arthritis
		Seizures / Convulsions
		Sexually Transmitted Disease
		Sleep Apnea
		Stomach Ulcer
		Stroke / CVA of the Brain
		Suicide Attempt
		Tuberculosis

NO MEDICAL HISTORY

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

FAMILY MEDICAL HISTORY

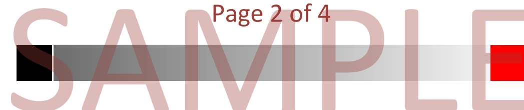
Please indicate if YOUR FAMILY has a history of the following.

Family History UNKNOWN **ADOPTED**

Please indicate which family member(s) have had these illnesses.	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Alcohol Abuse								
Anemia								
Arthritis								
Asthma								
Bipolar								
Bleeding Disease								
Breast Cancer (Before 50)								
Breast Cancer (After 50)								
CHF (Heart Failure)								
Colon Cancer (Before 50)								
Colon Cancer (After 50)								
COPD / Emphysema								
Depression								
Diabetes Type 2 (Adult)								
Diabetes Type 1								

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

Copyright © PatientLink Card 248 (Rev. 02/15/2012)


SAMPLE

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient 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

FAMILY MEDICAL HISTORY continued

Please indicate which family member(s) have had these illnesses.	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
High Cholesterol	○	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○	○
Hypothyroidism (Low Thyroid)	○	○	○	○	○	○	○	○
Migraines	○	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○	○
Seizures / Convulsions	○	○	○	○	○	○	○	○
Stroke / CVA of the Brain	○	○	○	○	○	○	○	○
NONE ○								

○ Mother, Grandmother, or Sister developed Heart Disease before the age of 65.
○ Father, Grandfather, or Brother developed Heart Disease before the age of 55.

FEMALE 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 stillbirths:	○	○	○	○	○	○	○	○
Number of premature births:	○	○	○	○	○	○	○	○
Number of miscarriages:	○	○	○	○	○	○	○	○
Number of abortions:	○	○	○	○	○	○	○	○

HAVE YOU HAD THE FOLLOWING?

				If yes, please list approximate date
Pap smear	yes ○	no ○	n/a ○	month / day / year
Abnormal pap smear	yes ○	no ○	n/a ○	month / day / year
Mammogram	yes ○	no ○	n/a ○	month / day / year

If "yes", were the results: normal ○ abnormal ○
If "yes", where was it done: ______

Bone density / Dexa scan	yes ○	no ○	n/a ○	month / day / year

Please write in the start date of your last menstrual period: 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?

abstinence ○ intra-uterine device (IUD) ○ rhythm method ○
condom ○ pill / injection / patch / ring ○ surgical sterilization ○
other ○

MALE PREVENTATIVE HEALTH (Men Only)

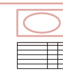
HAVE YOU HAD THE FOLLOWING?

				If yes, please list approximate date
Prostate cancer screening	yes ○	no ○	n/a ○	month / day / year
Any problems with sexual activity	yes ○	no ○	n/a ○	

Copyright © PatientLink Card 248 (Rev. 02/15/2012)
SAMPLE

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient Medical History
Age 13 and older



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

PREVENTATIVE HEALTH (Both Men and Women)

HAVE YOU EVER HAD ANY OF THE LISTED COLON SCREENINGS?

				If yes, please list approximate date
Colonoscopy	yes	no	don't know	month / day / year
If "yes", were the results:		normal	abnormal	month / day / year
Stool Hemocult (blood in stool)	yes	no	don't know	month / day / year

HAVE YOU EVER BEEN IMMUNIZED AGAINST THE FOLLOWING?

Human Papillomaviruses (HPV)	yes	no	don't know	month / day / year
Influenza (Flu) within the past year	yes	no	don't know	month / day / year
Measles, Mumps & Rubella (MMR)	yes	no	don't know	month / day / year
Pneumonia	yes	no	don't know	month / day / year
Shingles (Zostavax)	yes	no	don't know	month / day / year
Tentanus / Diphtheria (Adacel) in last 10 yrs	yes	no	don't know	month / day / year
Meningitis	yes	no	don't know	month / day / year
Chickenpox (Varicella)	yes	no	don't know	month / day / year

ALLERGIES

Please mark all allergies you have.

- I HAVE NO KNOWN ALLERGIES
- Latex Rubber Allergy
- Contrast or Iodine Allergy
- Anaphylactic / Other Reaction Anesthesia

Please list any medications or injections that have given you bad reactions. If possible, include your reactions
(hives, rash, itching, headaches, nausea, diarrhea, fainting, shock, shortness of breath, etc.)

Name of Medication	Reaction

MEDICATIONS

What medications are you taking at this time?
(Include prescription medications and over the counter medications or herbal supplements.
e.g. Aspirin, Motrin, Vitamins, St. John's Wort, etc.)

NOT ACTIVELY TAKING ANY MEDICATIONS - **PRESCRIPTION OR OTHERWISE**

Name of PRESCRIPTION MEDICATION	Dosage	Frequency

Name of OTC or HERBAL	Dosage	Frequency

Copyright © PatientLink Card 248 (Rev. 02/15/2012)