MRN#

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

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
- ○ Laparoscopy
- ○ 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

Cesarean Section 1 ○ 2 ○ 3 or more ○

Heart Valve Replacement mitral ○ aortic ○ tricuspid ○ unknown valve ○

Other Surgery (please specify): _____

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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		PAST	CURRENT	
◯	◯	Abnormal Pap Smear	◯	◯	High Blood Pressure
◯	◯	Alcohol Abuse	◯	◯	High Cholesterol
◯	◯	Allergies / Sinus		◯	HIV /AIDS
◯	◯	Alzheimers	◯	◯	Hypothyroid (Low Thyroid)
◯	◯	Anemia	◯	◯	Irritable Bowel Disease
◯	◯	Anxiety	◯	◯	Kidney Stones
◯	◯	Arthritis	◯	◯	Liver Cancer
◯	◯	Asthma	◯	◯	Lung Cancer
◯	◯	Birth Defects	◯	◯	Lupus
◯	◯	Bleeding Disease	◯	◯	Melanoma (Skin)
◯	◯	Blindness	◯	◯	Migraines
◯	◯	Blood Clots in Lung or Leg	◯	◯	Multiple Sclerosis
◯	◯	Breast Cancer	◯	◯	Osteoporosis
◯	◯	Bipolar Disorder	◯	◯	Parkinson's Disease
◯	◯	Cataracts	◯	◯	Prostate Cancer
◯	◯	Cervical Cancer	◯	◯	Prostate Problems
◯	◯	Colon Cancer	◯	◯	Paraplegia
◯	◯	Congestive Heart Failure	◯	◯	Quadraplegia
◯	◯	COPD / Emphysema	◯	◯	Reflux / GERD
◯	◯	Coronary Artery Disease	◯	◯	Rheumatic Fever
◯	◯	Crohn's Disease	◯	◯	Rheumatoid Arthritis
◯	◯	Depression	◯	◯	Seizures / Convulsions
◯	◯	Diabetes Type 1	◯	◯	Sexually Transmitted Disease
◯	◯	Diabetes Type 2	◯	◯	Sleep Apnea
◯	◯	Glaucoma	◯	◯	Stomach Ulcer
◯	◯	Gout	◯	◯	Stroke / CVA of the Brain
◯	◯	Hearing Loss	◯	◯	Suicide Attempt
◯	◯	Heart Attack	◯	◯	Tuberculosis
◯	◯	Hepatitis B			
◯	◯	Hepatitis C		◯	**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	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes Type 1	◯	◯	◯	◯	◯	◯	◯	◯

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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 PREVENTIVE 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:	○	○	○	○	○	○	○	○

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 PREVENTIVE HEALTH (Men Only)

Any problems with sexual activity? yes ○ no ○ n/a ○

PREVENTIVE HEALTH (Both Men and Women)

HAVE YOU EVER BEEN IMMUNIZED AGAINST THE FOLLOWING?				If yes, please list approximate date
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
Tetanus / 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

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PREVENTIVE HEALTH (Both Men and Women) continued

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	Were the results: Normal	Abnormal	Don't Know
Mammogram	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colonoscopy	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pap Smear	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bone Density / Dexa Scan	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Prostate Cancer Screening	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stool Hemoccult (blood in stool)	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Eye Exam	○	○	○	○	○	○	○	○	○	○	○	○	○	○

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

During the past month, have you often been bothered by feeling down, depressed or hopeless? yes ○ no ○

During the past month, have you often been bothered by little interest or pleasure in doing things? yes ○ no ○