Medical History

Patient Name: _____ Date of Birth: _____

I have recently traveled outside the United States ☐ NO ☐ YES If YES, Where & When_____

We would like for you to answer these questions so we can provide the best care possible. Sometimes emotional symptoms have influence on your body and physical illness can affect your emotions. This form is part of your case history and is confidential.

	YES	NO		YES	NO
I have poor appetite or unusual eating habits	☐	☐	I sleep badly	☐	☐
I have fits or convulsions or epilepsy	☐	☐*	I am under medical care	☐	☐
I have or have had anemia or thin blood	☐	☐	I am allergic to certain things	☐	☐
I drink 5-10 cups of coffee per day	☐	☐	I have high blood pressure	☐	☐
I have fainted or passed out frequently	☐	☐	I have/had cancer	☐	☐
I have trouble breathing or shortness of breath	☐	☐*	I drink 3 or more colas per day	☐	☐
My heart beats too fast or irregularly	☐	☐*	I have headaches often	☐	☐
I smoke ____ packs of cigarettes per day	☐	☐	I have trouble with my eyes	☐	☐
I have constipation or diarrhea frequently	☐	☐	I have trouble with my ears	☐	☐
I often have blood in my bowel movements	☐	☐*	I have thyroid trouble	☐	☐
I have had liver trouble or hepatitis	☐	☐	I have asthma or emphysema	☐	☐
I drink ____ mixed drinks per day/week	☐	☐	I have pains in my chest	☐	☐*
I drink ____ beers per day/week	☐	☐	I have heart trouble	☐	☐*
I have trouble with my kidneys or bladder	☐	☐	I cough up blood	☐	☐*
I am in pain when I urinate or pass water	☐	☐*	I have had tuberculosis	☐	☐*
I have had a sexually transmitted disease	☐	☐	I have diabetes	☐	☐
I have used narcotics or other habit forming drugs	☐	☐	I have or have had an ulcer	☐	☐
I have arthritis or stiff and painful joints	☐	☐	I often feel sick to my stomach	☐	☐
I have had a recent unusual change in weight	☐	☐	I have trouble with my balance	☐	☐*

***If any of these are answered Yes, confirm they are being addressed by PCP or refer to PCP**

TUBERCULOSIS SCREEN: ☐ Unexplained weight loss ☐ Productive cough (> 3 weeks) ☐ Night sweats

- ***If all 3 present, immediately refer to PCP***

WOMEN ONLY

# of Pregnancies: ☐ # of Live Births: ☐ # of Abortions: ☐ # of Miscarriages: ☐

	YES	NO		YES	NO
I am pregnant	☐	☐	I am using birth control	☐	☐
I am now going through the change of life	☐	☐	I have hot flashes and sweats	☐	☐
I have severe pains during menstrual periods	☐	☐	I receive hormone treatments	☐	☐
I am very nervous during menstrual periods	☐	☐	I have had a hysterectomy	☐	☐

Primary Care Provider/Physician: _____ Phone #: _____

Date last Physical Exam:_____ Current on all Immunizations? ☐ Yes ☐ No

Brief summary of any current medical conditions / diagnoses: _____

_____

_____

_____

ALLERGIES: (Include medications, foods, seasonal, dye, latex, etc.) ☐ None

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Brief summary of any past medical history (treatment procedures, diagnoses or problem, etc.): _____

_____

_____

History of: ☐ HIV/Aids ☐ Hepatitis; Type:____ STDs:_____

Relevant Family History: _____

_____

_____

VISION SCREENING:

Last eye exam? _____ Any problems? ☐ No ☐ Yes if yes, explain: _____

DENTAL SCREENING:

Provider: _____ Date of Last Exam: _____

Describe any current problems: _____

CHILD / ADOLESCENT ONLY

Is your child current on all immunizations? ☐Yes ☐No ***PLEASE PROVIDE COPY FOR RECORDS***

Do you have any concerns regarding your child's use of drugs or alcohol? ☐ No ☐ Yes If Yes, explain: _____

_____

Do you have any concerns about your child being sexually active? ☐ No ☐ Yes If Yes, explain: _____

_____

Has your child been sexually abused? ☐Yes ☐No physically abused? ☐ Yes ☐ No

CLINICIAN SUMMARY

_____

_____

_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Authorized Representative Date

_____ _____

Signature of Staff Reviewing Date