**Medical Health History Form**

**Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_**

*The following medical questionnaire is confidential and will not be released to anyone unless you authorize us to do so.*

**Current Medications:** What medications are you currently taking (please include name, dose, and how often you take)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History:** Have you ever had any of the following? If so, please explain in detail in the space to the right of each listed. **Allergies/Intolerances:** Please list any allergies or intolerances and what reaction happens. Please list medication allergies and any other allergies. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes

1. High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Heart Trouble \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. High cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Hepatitis or liver problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Bladder or urinary problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Bowel or gastrointestinal problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Asthma, Allergies, or hay fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Migraine Headaches \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Lung/Respiratory Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. Anxiety/Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes

14. Other Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Anemia or Other Blood Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Sexually Transmitted Disease(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Other Reproductive Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Seizures or Epilepsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Other Neurological Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Thyroid Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Arthritis or other joint problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Drug or alcohol abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Skin disease or cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25. Any other serious medical conditions?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical and Hospitalization History:** Have you ever had surgeries, or have you ever been hospitalized? Please list below along with date. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Have any blood relatives (parents, grandparents, uncles, aunts, brothers, sisters cousins, children) ever had?

Yes Who?

High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Defects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Abnormality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures/Epilepsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes Who?

Allergies or Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Trouble \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

**Tobacco Use**:  Do Not Use Cigarettes Oral Tobacco Number of cigarettes per day\_\_\_\_\_How soon after you wake up do you smoke your first cigarette?\_\_\_\_\_\_ Are you interested in quitting? Yes No

**Alcohol Use:**  Do Not Use Social Drinker Number of Drinks per week\_\_\_\_\_ Type of alcohol\_\_\_\_\_\_\_\_\_\_

**Drug Use:** Do Not Use Marijuana IV Drugs Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**: Single Married Divorced Widowed Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Education Level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you sexually active?** Currently Previously but not currently High Risk Sexual Activity (multiple partners, history of STDs)

**Exercise:** None Occasionally Regularly What Kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_For How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caffeine Use:** Do Not Use Occasionally Number of times per day\_\_\_\_\_\_\_\_Type of Caffeine\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems:** Check all that you have had in the past 3 months

* Fatigue Sore Throat Frequent Urination Sleep Changes
* Fever/Chills Sore(s) in Mouth Blood in Urine Depression
* Loss of Appetite Chest Pain Bladder Control Loss Problems Focusing
* Night Sweats Palpitations Painful Urination Disturbing Thoughts
* Sleep Disturbance Irregular Heartbeat Back Pain Hyperactivity
* Weight Gain Ankle/Leg Swelling Joint Pain Moodiness
* Weight Loss Cough Joint Stiffness Suicidal Thoughts
* Vision Changes Snoring Limited Movement Change in Periods
* Irritated Eyes Irregular Breathing Muscle Pain/Cramps Excessive Sweating
* Dizziness Wheezing Muscle Weakness Excessive Thirst
* Hearing Loss Abdominal Pain Neck Pain Excessive Hunger
* Ringing in Ears Constipation Skin Changes/Rashes Problems with Heat
* Hoarseness Diarrhea Fainting/Black Outs Problems with Cold
* Nasal Obstruction Heartburn Speech Difficulty Abnormal Bleeding
* Nose Bleeds Swallowing Problems Headaches Bruising
* Postnasal Drip Nausea or Vomiting Memory Loss
* Sinusitis Difficulty Urinating Anxiety

**Screenings/Prevention:**

Have you ever had any of the following immunizations? If so, when?

Influenza (flu) Pneumonia Tetanus Hepatitis B

Date: \_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you had fasting blood work completed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was it normal? Yes No

***Male Patients:*** Please complete the following:

When was your last prostate exam or PSA blood test level checked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you were checked for colon/rectal cancer (either with colonoscopy or through rectal exam)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Female patients:*** Please complete the following:

Last Menstrual Period began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you periods regular? Yes No

Age You Started Menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you menstruate? Every\_\_\_\_\_days.

How long do your periods last?\_\_\_\_\_\_days. Bleeding is mild moderate  severe.

Do you have any cramps? Yes No

Total Number of Pregnancies:\_\_\_\_\_\_\_\_Births:\_\_\_\_\_\_\_\_\_Miscarriages:\_\_\_\_\_\_\_

Do you use birth control? Yes No

What Form of Birth Control?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you happy with this method? Yes No

When was your last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ History of any abnormal mammograms? Yes No

When was the last time you were checked for colon/rectal cancer (either with colonoscopy or through rectal exam)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Concerns:** Any other concerns you would like to address with the Provider today during your visit?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Last Revised: 08/09/21*