

MEDICAL HISTORY FORM

Patient Name: _____ DOB: ____/____/____

Signature: _____ Date: ____/____/____

Present Health Concerns: _____

MEDICATIONS: Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.

Medication Name	Dose	Frequency

ALLERGIES: List all reactions to medicines, foods and other agents.

Allergy	Reaction or Side Affect

**** If you are on 3 or more medications – please bring them with you to each appointment. ****

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems.

Congenital Heart Disease: please specify: _____	Cancer (Malignancy) please specify: _____	Hepatitis A, B, or C (specify) _____
Myocardial Infarction (Heart Attack)	Stroke	Date of Last Colonoscopy: _____
Hypertension (High Blood Pressure)	Coagulation (Bleeding/Clotting)	Date of last Tetanus Shot: _____
Diabetes	Depression/Suicide Attempt	Date of last HIV Test: _____
High Cholesterol	Alcoholism	Date of Blood Transfusion: _____
		Other: _____

SURGICAL HISTORY: Please list all prior surgeries and dates.

Surgery	Date

IMMUNIZATIONS: Please list your most recent immunizations, not including those administered at Lowell General Hospital. Please include your best estimate of the month and year of each immunization.

Hepatitis A: _____ Measles: _____ Mumps: _____ Rubella: _____ MMR: _____
Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Other: _____

WOMEN’S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: (For Women Only)

of Pregnancies: _____ # of Deliveries: _____ # of Abortions: _____ # of Miscarriages: _____ Age at 1st menses: _____
Frequency of menses: _____ Length of menses: _____ Date of last menses: _____ Date of last mammogram: _____

Do you have any concerns about your period or menopause? Yes No Please explain: _____

Have you ever had an abnormal pap smear? Yes No If circled yes, when was it? _____

FAMILY HISTORY: Please indicate with a check (✓) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: <i>(please write in)</i>											

SOCIAL HISTORY:

Exercise:

Do you exercise regularly? Yes No

Tobacco Use:

Current Never Former: quit on: _____

*If current # of packs/day ___ # of years _____

Other Tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? No Yes

Drug Use:

Do you use any recreational drugs?

Yes No

If yes please list _____

If you have used in the past, how long have you been drug free? _____

Have you ever used needles for IV drug use? Yes No

Alcohol Use

Do you drink alcohol? Yes No

If yes, # of drinks per week: _____

What type of alcohol: _____

Is alcohol a concern for you or others who surround themselves around you? Yes No

SAFETY

Do you wear a seatbelt regularly? Yes No

Do you wear a bike helmet regularly?

Yes No

Do you feel safe at home? Yes No

Do you feel safe in your current relationship?

Yes No

Have you ever been physically or sexually abused? Yes No

Do you have a gun in your home?

Yes No

Are you a member of a gang? Yes No

Other concerns: _____

SOCIOECONOMICS

Occupation: _____

Degree of education completed: _____

Marital Status: _____

Spouse/Partner's Name: _____

Who lives at home with you? _____

SEXUALITY

Are you sexually active? Yes No

Current sex partner(s) are: male female

If sexually active do you practice safe sex?

Yes No

Other Concerns: _____

Birth Control Method: _____

Have you ever had a sexually transmitted disease? Yes No

If yes, please include: _____

Are you interested in being screened for sexually transmitted diseases? Yes No

Other Services

Have you had a recent eye exam? Yes No

Have you had a recent dental exam?

Yes No

Do you see any other specialists? _____

EMOTIONS

In the past year, have you had 2 or more weeks during which you felt sad or depressed; or you lost all interest or pleasure in things that you usually cared about or enjoyed? Yes No

Have you had 2 or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes? Yes No

Have you felt depressed or sad much of the time in the past year? Yes No

Do you ever feel like hurting yourself or others? Yes No

REVIEW OF SYSTEMS: Please indicate with a check (✓) any current problems you have below.

Constitutional

Fevers/chills/sweats
Unexplained weight loss/gain
Fatigue/weakness
Excessive thirst or urination
Other: _____

Cardiovascular

Chest pain/discomfort
Leg pain with exercise
Heart murmur or heart problems
Palpitations
Other: _____

Chest

Breast lump/discharge
Other: _____

Ears/Nose/Throat/Mouth

Difficulty hearing/ringing in ears
Hay fever/allergies
Problems with teeth/gums
Difficulty swallowing
Difficulty with speech
Other: _____

Endocrine

Hypothyroid
Hyperthyroid
Abnormal hormone levels
Abnormal blood glucose levels
Other: _____

Eyes

Changes in vision
Farsighted
Nearsighted
Other: _____

Gastrointestinal

Abdominal pain
Blood in bowel movement
Nausea/vomiting/diarrhea
Other: _____

Genitourinary

Nighttime urination
Incontinence
Sexual function problems
Discharge from penis
Other: _____

Gynecological

Abnormal vaginal bleeding
Problems with conceiving
Problems with contraception
Vaginal discharge
Vaginal odor
Painful intercourse
Other: _____

Lymphatic/Blood

Unexplained lumps
Easy bruising/bleeding
Anemia
Other: _____

Musculo-skeletal

Muscle/joint pain
Arthritis
Other: _____

Neurological

Headaches
Dizziness/light-headedness
Numbness
Memory loss
Loss of coordination
Epilepsy or convulsive seizures
Other: _____

Psychiatric

Anxiety/stress
Problems with sleep
Depression
Suicidal ideations
Other: _____

Respiratory

Cough/wheeze
Difficulty breathing
Asthma
COPD
Sleep apnea
Other: _____

Skin

Rash or mole change(s)
Psoriasis
Eczema
Other: _____
