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.*

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

***\*\* 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.*

Cancer (Malignancy)

*please specify*:

Congenital Heart Disease:

*please specify*:

Hepatitis A, B, or C (*specifiy)*

Date of Last Colonoscopy:

Stroke

Coagulation (Bleeding/Clotting) Depression/Suicide Attempt Alcoholism

Myocardial Infarction (Heart Attack)

Hypertension (High Blood Pressure) Diabetes

High Cholesterol

Date of last Tetanus Shot: \_

Date of last HIV Test: \_

Date of Blood Transfusion: \_

Other: \_

**SURGICAL HISTORY:** *Please list all prior surgeries and dates.*

**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 Miscarriages: Age at 1st menses:

# of Pregnancies: # of Deliveries:

# of Abortions:

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?

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**Surgery**

**Date**

Allergy

Reaction or Side Affect

**Medication Name**

**Dose**

**Frequency**

□

□

**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.*

**SOCIAL HISTORY:**

**Exercise:**

Do you exercise regularly? □ Yes □ No

**Tobacco Use:**

* Current □ Never □ Former: quit on:

**Drug Use:**

Do you use any recreational drugs?

* Yes □ No

If yes please list

**Alcohol Use**

Do you drink alcohol? □ Yes □ No

If yes, # of drinks per week: \_

What type of alcohol:

If you have used in the past, how long

have you been drug free?

\*If current # of packs/day # of years

Is alcohol a concern for you or others who

surround themselves around you?

* Yes □ No

**Other Tobacco:** □ Pipe □ Cigar □ Snuff □ Chew

Are you interested in quitting? □ No □ Yes

Have you ever used needles for IV drug

use?

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

**SOCIOECONOMICS**

Occupation:

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:

Degree of education completed:

Marital Status:

Spouse/Partner’s Name:

Who lives at home with you? \_

\_

**SEXUALITY**

Are you sexually active?

**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?

* Yes □ No

Birth Control Method: \_

Current sex partner(s) are: □ male □ female

If sexually active do you practice safe sex?

* Yes □ No

Other Concerns:

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

\_

**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 of others? □ Yes □ No

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**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: *(please write in)*

**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:

***Eyes***

Changes in vision Farsighted Nearsighted

Other:

***Musculo-skeletal***

Muscle/joint pain Arthritis

Other:

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***Neurological***

Headaches

Dizziness/light-headedness Numbness

Memory loss

Loss of coordination

Epilepsy or convulsive seizures Other:

***Gastrointestinal***

Abdominal pain

Blood in bowel movement Nausea/vomiting/diarrhea

Other:

***Cardiovascular***

Chest pain/discomfort Leg pain with exercise

Heart murmur or heart problems Palpitations

Other:

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***Genitourinary***

Nighttime urination Incontinence

Sexual function problems Discharge from penis

Other:

***Psychiatric***

Anxiety/stress Problems with sleep Depression

Suicidal ideations

Other:

***Chest***

Breast lump/discharge

Other:

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***Ears/Nose/Throat/Mouth***

Difficulty hearing/ringing in ears Hay fever/allergies

Problems with teeth/gums Difficulty swallowing Difficulty with speech

Other:

***Gynecological***

Abnormal vaginal bleeding Problems with conceiving Problems with contraception Vaginal discharge

Vaginal odor Painful intercourse

Other:

***Respiratory***

Cough/wheeze Difficulty breathing Asthma

COPD

Sleep apnea

Other:

\_

\_

***Endocrine***

Hypothyroid Hyperthyroid

Abnormal hormone levels Abnormal blood glucose levels Other:

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***Lymphatic/Blood***

Unexplained lumps Easy bruising/bleeding Anemia

Other:

***Skin***

Rash or mole change(s) Psoriasis

Eczema

Other:

\_

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