

## 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 1<sup>st</sup> 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: \_\_\_\_\_  
\_\_\_\_\_