Merrimack Family Medicine
Lowell General Hospital

www.merrimackfamilymedicine.com
600 Clark Road, Ste. 3
Tewksbury, MA 01876
Tele: 978-851-4141
Fax: 978-640-9840

Patient Medical History

Please complete the following questionnaire to the best of your ability. If there are any questions you prefer not answering leave them blank.

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

Present Health Concerns: _____

_____

_____

MEDICATIONS: Please list all prescription and non-prescription medicine

Medication Name	Dose	Frequency

ALLERGIES: Please list all known allergies

Medication / Food	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 (with approximate date of illness or diagnosis):

_____ Congenital Heart Disease
specify type: _____
_____ Myocardial Infarction (Heart attack)
_____ Diabetes
_____ High Cholesterol
_____ Stroke
_____ Thyroid problem
specify type: _____

_____ Cancer (malignancy)
Specify type: _____
_____ Coagulation (bleeding / clotting)
_____ Depression / suicide attempt
_____ Alcoholism
_____ Date of last Tetanus shot
_____ Date of last HIV test
_____ If you have ever had a blood transfusion, please specify date: _____

Other problems:

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

Surgery / Name of Hospital	Date

WOMEN'S GYNECOLOGIC/OBSTETRIC HISTORY:

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Number of pregnancies: _____	Number of deliveries: _____	Number of abortions: _____	Number of miscarriages: _____
1st day of most recent period: _____	Age at 1st period: _____	Frequency of periods: _____	Length of each: _____-

Do you have any concerns about your periods? ☐ Yes ☐ No: Please specify: _____

Do you have any concerns about menopause? ☐ Yes ☐ No: Please specify: _____

Abnormal Pap smear? ☐ Yes ☐ No: Please specify: _____

FAMILY HISTORY

Please indicate with a checkmark family member who have had any of the following conditions:

Medical Condition	Mother	Father	Sister	Brother	Daughter	Son	Other Close Relative
Alcoholism							
Anemia							
Anesthesia Problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Cancer (specify type)							
Depression							
Diabetes (specify type)							
Eczema							
Epilepsy (Seizures)							
Genetic Diseases							
Glaucoma							
Hearing Problems							
Heart Condition							
High Blood Pressure							
Kidney Disease							
Osteoporosis							
Stroke							
Thyroid Disorder							
Tuberculosis							
Other							

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SOCIAL HISTORY:

SUBSTANCES

Tobacco Use

Cigarettes

☐Current: Smoker: packs/day: _____ number of years: ____

☐Never

☐Quit: Date: _____

Other Tobacco:☐Pipe☐ Cigar ☐ Snuff ☐Chew

Are you interested in quitting? ☐No ☐ Yes

Alcohol Use

Do you drink alcohol?☐ Yes☐No: Number drinks/week _____

What type of alcohol? _____

Is alcohol use a concern for you or others? Yes No

☐ ☐

Drug Use

Do you use any recreational drugs? ☐Yes ☐ No

If yes, please list: _____

If not using currently but used in the past how long have you been clean? ___

Have you ever used needles? ☐Yes☐ No

Exercise

Do you exercise regularly:☐ Yes ☐No

SOCIOECONOMICS

Occupation: _____

Education completed: ☐ Grade School ☐ High School ☐ College ☐ Graduate

School

Marital Status: ☐ Single ☐ Married ☐ Seperated ☐ Divorces ☐ Widowed☐ Domestic Partner ☐ Engaged ☐ Other

Spouse / Partner's name: _____

Number of children: _____

Who lives at home with you? _____

SAFETY:

Do you use seatbelts consistently?	Yes	No	
Do you use a bike helmet regularly?	Yes	No	NA
Is violence at home a concern for you?	Yes	No	
Do you feel safe in your current relationship?	Yes	No	NA
Have you ever been physically or sexually abused?	Yes	No	NA
Do you have a gun in your home?	Yes	No	NA
Are you a member of a gang?	Yes	No	

Other concerns:

_____

_____

SEXUALITY:

Sexual Activity

Sexually Active: ☐ Yes ☐ No ☐ Not currently

Current sex partner(s) is / are: ☐ male ☐ female

Contraception and Protection

Brth Control Method: _____

If sexually active, do you practice safe sex? ☐Yes ☐ No

Have you ever had any sexually ransmitted diseases (STDs)?

If yes, add additional information:

_____ Date: _____

_____ Date: _____

Any treatment?: _____

Are you interested in being screened for sexually transmitted disease(s) ? ☐ Yes ☐ No

Other concerns: _____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest r pleasue in things that you usually cared about or enjoyed? ☐ Yes ☐ No
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No
3. Have you felt depressed or sad much of the time in the past year? ☐ Yes ☐ No
4. Do you ever feel like hurting yourself or others? ☐ Yes ☐ No

IMMUNIZATIONS:

Please list your most recent immunizations, not including those administered at Merrimack Family Medicine.

Please include your best estimate of the month and year of each immunization:

Hepatitis A _____ Measles _____ Mumps _____ Rubella _____ Pneumovax (Pneumonia) _____

Hepatitis B _____ MMR _____ Tetanus (Td) _____ Varicella (chicken pox) _____ Other _____