Merrimack Family Medicine
LOWELL GENERAL HOSPITAL

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Medical History Form ______________________________ / ________

Please complete All **3** PAGES in **black ink** Patient's Name Date of Birth

Your answers on this form will help us better understand your medical concerns and conditions. **Thank you!**

PRESENT HEALTH CONCERNS: ____

____

____

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

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication/Food	Reaction or Side Affect

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

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)
_____Hypertension (high blood pressure)
_____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 (Please list all prior operations and dates)**:**

Operation	Date

WOMEN'S GYNECOLOGIC/OBSTETRIC HISTORY:

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

Do you have any concerns about your periods? □ Yes □ No: ______________________________
Do you have any concerns about menopause? □ Yes □ No: ______________________________
Abnormal Pap smear? □ Yes □ No: ______________________________

FAMILY HISTORY:

Please indicate with a check (√) family members 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 (Type)							
Depression							
Diabetes (Type)							
Eczema							
Epilepsy (Seizures)							
Genetic Diseases							
Glaucoma							
Hearing Problems							
Heart Condition							
High Blood Pressure							
Kidney Disease							
Migraine Headaches							
Osteoporosis							
Stroke							
Thyroid Disorder							
Tuberculosis							
Other							

SOCIAL HISTORY:

SUBSTANCES

Tobacco Use

Cigarettes
□ Current: Smoker: packs/day____ # of yrs ________
□ Never
□ Quit: Date__________
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Alcohol Use

Do you drink alcohol? □ Yes □ No: # 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 □ Separated □ Divorced □ Widowed □ Domestic Partner □ Engaged □ Other
Spouse/Partner's name: ____________________
Number of children: ___________
Who lives at home with you? ______________________

SAFETY:
Do 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
Do you have a gun in your home? □ Yes □ No
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
Birth Control method:____________________ N/A
If sexually active, do you practice safe sex? □ Yes □ No □NA
Have you ever had any sexually transmitted diseases (STDs)? If yes, please include:
_______________________date_______
_______________________date_______
Any treatment? _____________________
Are you interested in being screened for sexually transmitted disease? □ 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 or pleasure 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 he 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________

REVIEW OF SYSTEMS: Please check (√) any current problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination

Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations

Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea

Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination

Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression

Eyes
___Change in vision

Chest (breast)
___Breast lump/discharge
________ Date of last mammogram

Genitourinary
___Nighttime urination
___Leaking urine
___Sexual function problems
___Discharge from penis

Gynecological
___Abnormal vaginal bleeding
___Problems with conception
___Problems with contraception
___Vaginal discharge
___Vaginal odor
___Painful sexual intercourse

Ears/Nose/Throat/Mouth
___Difficult hearing/ringing in ears
___Hay fever/allergies
___Problems with teeth/gums

Respiratory
___Cough/wheeze
___Difficulty breathing

Musculo-skeletal
___Muscle/joint pain

Skin
___ Rash or mole change

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding

*Other (please specify)*____
____
____