Place Sticker

PATIENT MEDICAL HISTORY FORM DATE: _____

☐ **Self** ☐ **Family History** (Mother/Father/Brother/Sister **Only**)

- ☐ ☐ Alcoholism/drug addiction
- ☐ ☐ Anemia
- ☐ ☐ Arthritis
- ☐ ☐ Asthma
- ☐ ☐ Bleeding disorder
- ☐ ☐ Blood clot in leg or lung
- ☐ ☐ Cancer – type: _____
- ☐ ☐ Developmental Disability (Circle if applicable)

(Autism Spectrum Disorder, Deafness, Blindness, Intellectual Disability or Cerebral Palsy)

- ☐ ☐ Diabetes – type: _____
- ☐ ☐ Epilepsy /Seizures
- ☐ ☐ Heart Disease / Attack
- ☐ ☐ Hepatitis – type: _____
- ☐ ☐ High blood pressure
- ☐ ☐ Kidney disease
- ☐ ☐ Lung disease (emphysema/TB)
- ☐ ☐ Mental Health Condition (Circle if applicable)

(Depression, Bipolar, Schizophrenia, Anxiety or ADHD)

- ☐ ☐ Migraines
- ☐ ☐ Rheumatic Heart Disease/Fever
- ☐ ☐ Sexually transmitted infection
- ☐ ☐ Stomach problems
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Conditions _____
- ☐ ☐ Ulcer
- ☐ ☐ Urinary problems / pain
- ☐ ☐ Other:_____

Hospitalization, surgery, serious injuries:

_____**year**_____
_____**year**_____
_____**year**_____

Exam/Test	**Where**	**Year**
Colon Screening	_____	_____
Type: ***Fecal Occult Blood*** ***Flex Scope*** ***Colonoscopy***		
Eye Exam	_____	_____
Dental Exam	_____	_____
Hgb A1C(Diabetes)	_____	_____

MEN's Health:

PSA/Rectal Exam _____ _____

Do you perform Self Testicular Exams? Yes No

Allergies:_____

Current Medications:

Include prescription, vitamins & over the counter/herbal preparations.

_____

_____

_____

_____

_____

_____

_____

Relationship status: ☐ Single ☐ Spouse/partner ☐ Widowed
Education (last grade completed): _____
Your occupation: _____
Do you feel physically and emotionally safe in your relationship and your home? ☐ Yes ☐ *No*
Do you have financial concerns? ☐ No ☐ *Yes*
Do you exercise? ☐ No ☐ Yes – activity: _____
How often? _____
Alcohol ☐ No ☐ Yes type: _____ frequency:_____
Drugs ☐ No ☐ Yes type: _____ frequency: _____
Tobacco ☐ No ☐ Yes # per day:_____ since:_____

If yes, *would you like help quitting?* ☐ *No* ☐ *Yes*

_____

WOMEN's Health: (12 years old and up)

First menstrual period – Age:_____
Last menstrual period – date: ____/____/____
☐ **Menopause** – year: _____

OB History: Pregnancies:_____ Living Children:_____
Miscarriages/ Abortions:_____
Birth control: ☐ none ☐ pills Other: _____

Mammogram Where_____ **Year:** _____
Do you perform Self Breast Exams? Yes No

Pap Exam Where _____ **Year:** _____

Consent for Record Release Obtained? YES NO

Roomer Initials: _____

Place Sticker

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