PATIENT MEDICAL HISTORY FORM DATE:_____ Patient Sticker

	Self	Family History (Mother, Father, Brother, Sister **Only**)
Alcohol or 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	☐	☐
Thyroid Conditions Type:_____	☐	☐
Ulcer	☐	☐
Urinary problems / pain	☐	☐
Other:_____	☐	☐

Hospitalization, surgery, serious injuries:
_____ Year:_____
_____ Year:_____
_____ Year:_____

Mens Health:

PSA/Rectal Exam: Where_____Year_____
Do you perform Self Testicular Exams? Yes No
Have you had any urology problems? Yes No

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: _____

Allergies:_____
_____
_____
_____

Current Medications (Include prescriptions, vitamins, and over the counter/herbal preparations):
_____
_____
_____
_____
_____

Exam/Test:

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

1. Do you have financial concerns related to food, housing, medical care, or heating. Very Hard Hard Somewhat Hard Not Very Hard
2. Education (last grade completed):_____
3. Your Occupation:_____
4. How would you describe your stress level?
Not at all Only a Little Some Rather Much Very Much
5. Do you exercise? Yes: Activity_____ No
How often:_____ How Long_____
6. Use alcohol? No Yes type: _____ frequency:_____
7. Use drugs? No Yes type: _____ frequency: _____
8. Use tobacco No Yes # per day:_____ since:_____
If yes, would you like help quitting? No Yes
9. Relationship status: Single, Spouse/Partner, Widowed, Divorced
10. Per week, how often do you:
Talk on the telephone with family/friends:_____
Get Together with family/friends:_____
Participate in clubs/community:_____
11. Do you feel physically and emotionally safe in your relationship and your home? Yes No
12. Do you have an advanced care directive? Yes No
13. Do you have a living will? Yes No
14. Do you have a power of attorney? Yes No
15. Would you like more information on advanced directives, living wills, or power of attorney? Yes No

Official Use Only

Consent for Record Release Obtained? Yes No
Roomer Initials:_____