

MEDICAL HISTORY FORM

Internal Use Only:

MCIR: Yes No

Name: _____
First Middle Initial Last

DOB: _____
MM / DD / YY

PAST HEALTH HISTORY	YES	NO
<i>Have you ever had any the following:</i>		
Asthma		
Diabetes		
Hay Fever		
Headaches		
High Blood Pressure		
Infectious Mono		
Frequent Anxiety		
Frequent Depression		
Suicidal Thoughts		
Pneumonia		
Menstrual Problems		
Pregnancy		
Seizures		
Sickle Cell Anemia		
Sexually Transmitted Diseases If yes, specify: _____		
Other: _____		

SURGICAL HISTORY	YES	NO
Have you ever had surgery? If yes, what kind? _____ When did you have this surgery? _____		

FAMILY MEDICAL HISTORY *Please mark if paternal/maternal	Fa	Mo	Sis	Bro	Gma	Gpa
<i>Check all that apply:</i>						
Healthy						
Health Unknown						
Deceased						
Allergies						
Asthma						
Cancer						
Depression						
Diabetes						
Heart Attack <40 Yrs						
Heart Disease						
High Blood Pressure						
Stroke						
Substance Abuse						
Domestic Violence						
Other:						

ALCOHOL USE	YES	NO
Do you drink alcohol? How often? _____ How much? _____		

DRUG USE	YES	NO
Do you ever use recreational drugs? What kind? _____ How often? _____		

SOCIAL HISTORY	YES	NO
Have you ever been emotionally _____, physically _____, or sexually _____ abused?		
Do you feel safe at home? At school? If yes, please circle.		
Are you concerned about violence or abuse at home? With others? If yes, please circle.		

SEXUAL HEALTH	YES	NO
Do you have sex with: Men: _____ Women: _____ Both: _____ N/A: _____		
How many partners have you had in the last 12 months? _____ 2 months? _____		
Do you give/receive oral sex? (circle) Condoms: Never__ Sometimes__ Always__		
Do you give/receive vaginal sex? (circle) Condoms: Never__ Sometimes__ Always__		
Do you give/receive anal sex? (circle) Condoms: Never__ Sometimes__ Always__		

MEDICATIONS	YES	NO
Do you have allergies to any medications? Please list: _____		
Are you currently taking any medications? (Including prescriptions, over the counter drugs, and birth control) Please list: _____ _____ _____		

PREFERRED PHARMACY INFORMATION
*This is where we will send your prescriptions at the end of your visit (if applicable) Name: _____ Address: _____ _____ Phone: _____

FOR PHYSICAL/CLEARANCE EXAMS ONLY

Circle all symptoms that apply in each category. If applicable, please **explain** answers in the provided area.

GENERAL

Loss of appetite, chills, dizziness, fatigue, fever, headache, night sweats, sleep disturbance
Explain: _____

EYES

Blurry vision, double vision, loss of vision, discharge, swelling
Date of last eye exam: _____
Explain: _____

EARS, NOSE & THROAT

Earache, decreased hearing, nasal congestion, sore throat, hoarseness
Date of last dental exam: _____
Explain: _____

HEART

Chest pain, fast or slow pulse, feeling faint, swelling in feet, elevated blood pressure
Explain: _____

LUNGS & BREAST

Cough, shortness of breath, wheezing, breast changes, breast lump, nipple discharge
Date of last clinical breast exam: _____
Explain: _____

GASTROINTESTINAL

Nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stool, heartburn
Explain: _____

URINARY

Feeling of incomplete emptying, pain with urination, urgent urination, frequent urination, blood in urine
Explain: _____

FEMALE GENITAL

Menstrual period absence, irregular periods, painful menstruation, vaginal discharge, painful intercourse, sores
Date of last menstrual period: _____
Date of last annual GYN exam: _____
Explain: _____

MALE GENITAL

Discharge, sores, erectile dysfunction
Explain: _____

MUSCULOSKELETAL

Back pain, joint pain or swelling, muscle weakness, stiffness, recent injury
Explain: _____

SKIN

Rash, hives, redness, itch, suspicious lesions
Explain: _____

NEUROLOGICAL

Numbness, tingling, seizures, fainting, tremors, paralysis, history of head injury
Explain: _____

MENTAL HEALTH

Depression, anxiety, suicidal thoughts, thoughts of hurting others, paranoia, hearing voices
Explain: _____

ENDOCRINE

Cold flashes, hot flashes, excessive thirst, weight loss, weight gain
Explain: _____

BLOOD

Abnormal bruising, abnormal bleeding, enlarged lymph nodes
Explain: _____

ALLERGIES & IMMUNITIES

Hay fever, HIV/STI exposure (occupational)
Explain: _____

HOW WOULD YOU DESCRIBE YOUR HEALTH IN GENERAL? _____

