MEDICAL HISTORY FORM

Internal Use Only:
MCIR: ☐Yes ☐No

Name: _____ DOB: _____
First Middle Initial Last MM / DD / YY

PAST HEALTH HISTORY		
Have you ever had any the following:	**YES**	**NO**
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

Check all that apply:	Fa	Mo	Sis	Bro	Gma	Gpa
Healthy					n/a	n/a
Health Unknown					n/a	n/a
Deceased					n/a	n/a
Allergies					n/a	n/a
Asthma					n/a	n/a
Cancer					n/a	n/a
Depression					n/a	n/a
Diabetes					n/a	n/a
Heart Attack <40 Yrs					n/a	n/a
Heart Disease					n/a	n/a
High Blood Pressure					n/a	n/a
Stroke					n/a	n/a
Substance Abuse					n/a	n/a
Domestic Violence					n/a	n/a
Other:					n/a	n/a

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?** _____