Drum Hill Primary Care

MEDICAL HISTORY FORM

Patient Name: ______________________ DOB: ______/______/_______

Signature: _________________________ Date: _____/______/________

Present Health Concerns: ____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

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

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

___Congenital Heart Disease:
please specify:__________________
___Myocardial Infarction (Heart Attack)
___Hypertension (High Blood Pressure)
___Diabetes
___High Cholesterol

___Cancer (Malignancy)
please specify:__________________
___Stroke
___Coagulation (Bleeding/Clotting)
___Depression/Suicide Attempt
___Alcoholism

___Hepatitis A, B, or C (*specifiy)*_______
Date of Last Colonoscopy: _____________
Date of last Tetanus Shot: _____________
Date of last HIV Test: ________________
Date of Blood Transfusion: ___________
Other:_____________________________

SURGICAL HISTORY: *Please list all prior surgeries and dates.*

Surgery	Date

IMMUNIZATIONS: *Please list your most recent immunizations, not including those administered at Lowell General Hospital. Please include your best estimate of the month and year of each immunization.*

Hepatitis A: _________ Measles: ___________ Mumps: _____________ Rubella: _____________ MMR: _______________
Hepatitis B: _________ Pneumovax: ________ Tdap: _______________ Varicella: ___________ Other: ______________

WOMEN'S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: *(For Women Only)*

# of Pregnancies: _____ # of Deliveries: _____ # of Abortions: _____ # of Miscarriages: ____ Age at 1st menses: ____
Frequency of menses: ______ Length of menses: _____ Date of last menses: _______ Date of last mammogram: _______

Do you have any concerns about your period or menopause? □ Yes □ No Please explain: ____________________________________
Have you ever had an abnormal pap smear? □ Yes □ No When? ____

FAMILY HISTORY: *Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

SOCIAL HISTORY:

Exercise:
Do you exercise regularly? □ Yes □ No
Tobacco Use:
□ Current □ Never □ Former, quit on: _____
If current # of packs/day ___ # of years _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Drug Use:
Do you use any recreational drugs?
□ Yes □ No
If yes please list ____________________
If you have used in the past, how long have you been drug free? _________________
Have you ever used needles for IV Drug Use?
□ Yes □ No

Alcohol Use
Do you drink alcohol? □ Yes □ No
If yes, # of drinks per week: __________
What type of alcohol: _______________
Is alcohol a concern for you or others who surround themselves around you?
□ Yes □ No

SAFETY

Do you wear a seatbelt regularly? □ Yes □ No
Do you wear a bike helmet regularly?
□ Yes □ No
Do you feel safe at home? □ Yes □ No
Do you feel safe in your current relationship?
□ Yes □ No

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: _____________________
____

SOCIOECONOMICS

Occupation:__________________________
Degree of education completed:_________
Marital Status: ________________________
Spouse/Partner's Name: _______________
Who lives at home with you? ___________

SEXUALITY

Are you sexually active? □ Yes □ No
Current sex partner(s) are: □ male □ female
If sexually active do you practice safe sex?
□ Yes □ No
Other Concerns: _____________________
____

Birth Control Method: _________________
Have you ever had a sexually transmitted disease? □ Yes □ No
If yes, please include: __________________
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Other Services

Have you had a recent eye exam? □ Yes □ No
Have you had a recent dental exam?
□ Yes □ No
Do you see any other specialists? __________
____
____

EMOTIONS

In the past year, have you had 2 or more weeks during which you felt sad or depressed; or you lost all interest or pleasure in things that you usually cared about or enjoyed? □ Yes □ No
Have you had 2 or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes? □ Yes □ No
Have you felt depressed or sad much of the time in the past year? □ Yes □ No
Do you ever feel like hurting yourself of others? □ Yes □ No

REVIEW OF SYSTEMS: *Please indicate with a check (√) any current problems you have below.*

Constitutional
__Fevers/chills/sweats
__Unexplained weight loss/gain
__Fatigue/weakness
__Excessive thirst or urination
__Other: ______________________
____

Cardiovascular
__Chest pain/discomfort
__Leg pain with exercise
__Heart murmur or heart problems
__Palpitations
__Other: ______________________
____

Chest
__Breast lump/discharge
__Other: ______________________
____

Ears/Nose/Throat/Mouth
__Difficulty hearing/ringing in ears
__Hay fever/allergies
__Problems with teeth/gums
__Difficulty swallowing
__Difficulty with speech
__Other: ______________________
____

Endocrine
__Hypothyroid
__Hyperthyroid
__Abnormal hormone levels
__Abnormal blood glucose levels
__Other: ______________________
____

Eyes
__Changes in vision
__Farsighted
__Nearsighted
__Other: ______________________
____

Gastrointestinal
__Abdominal pain
__Blood in bowel movement
__Nausea/vomiting/diarrhea
__Other: ______________________
____

Genitourinary
__Nighttime urination
__Incontinence
__Sexual function problems
__Discharge from penis
__Other: ______________________
____

Gynecological
__Abnormal vaginal bleeding
__Problems with conceiving
__Problems with contraception
__Vaginal discharge
__Vaginal odor
__Painful intercourse
__Other: ______________________
____

Lymphatic/Blood
__Unexplained lumps
__Easy bruising/bleeding
__Anemia
__Other: ______________________
____

Musculo-skeletal
__Muscle/joint pain
__Arthritis
__Other: ______________________
____

Neurological
__Headaches
__Dizziness/light-headedness
__Numbness
__Memory loss
__Loss of coordination
__Epilepsy or convulsive seizures
__Other: ______________________
____

Psychiatric
__Anxiety/stress
__Problems with sleep
__Depression
__Suicidal ideations
__Other: ______________________
____

Respiratory
__Cough/wheeze
__Difficulty breathing
__Asthma
__COPD
__Sleep apnea
__Other: ______________________
____

Skin
__Rash or mole change(s)
__Psoriasis
__Eczema
__Other: ______________________
____