Confidential Medical History Form

Name _____ Date of birth _____

Have you EVER had any of the following?

Medical:

- ☐ ADD/ADHD
- ☐ Adrenal disorders
- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder disease
- ☐ Bleeding disorder
- ☐ Bulimia
- ☐ Cancer
- ☐ Celiac disease
- ☐ Chlamydia
- ☐ Clotting disorder
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Eczema
- ☐ Eye disorders
- ☐ Fractures
- ☐ Genital warts
- ☐ Gonorrhea
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Hives
- ☐ HPV
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Mononucleosis
- ☐ Irritable bowel syndrome
- ☐ Kidney stones
- ☐ Malaria
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Muscular dystrophy
- ☐ Paget's disease of bone
- ☐ Pneumonia
- ☐ PCOS
- ☐ Pregnancy
- ☐ Psoriasis
- ☐ Radiation therapy
- ☐ Seizures
- ☐ Sinusitis (chronic)
- ☐ Stroke
- ☐ Thyroid fever
- ☐ Tuberculosis
- ☐ Ulcerative colitis
- ☐ Chicken pox

Anesthesia History:

- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Pseudocholinesterase deficiency
- ☐ Spinal headache

☐ **I've had NO significant health problems**

Surgical:

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Ear tubes
- ☐ Knee ACL tear
- ☐ Knee arthroscopy
- ☐ Organ transplant
- ☐ Ovarian cyst removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight loss surgery

☐ Other surgical history:

_____
_____
_____
_____
_____
_____
_____
_____

Family History:

	Alcohol abuse	Clotting disorder	Breast cancer	Colon cancer	Melanoma cancer	Diabetes mellitus	Drug dependency	Heart disease	Hyperlipidemia	Hypertension	Learning disabilities	Mental illness	Stroke	Sudden cardiac arrest	Parent deceased	Brain tumor	Sleep apnea	Other
Mother																		
Father																		
Sister																		
Brother																		
Maternal Grandfather																		
Maternal Grandmother																		
Paternal Grandfather																		
Paternal Grandmother																		
Maternal Aunt																		
Maternal Uncle																		
Paternal Aunt																		
Paternal Uncle																		

☐ **Adopted** ☐ **Family history unknown**

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Be prepared to inform the nurse of current medications (including birth control, acne, over the counter medications, vitamins, etc.)

EXERCISE:

Do you exercise regularly?
- ☐ Yes
- ☐ No

I moderately exercise:
- ☐ Less than three times per week
- ☐ Three or more times per week

I strenuously exercise:
- ☐ Less than three times per week
- ☐ Three or more times per week

SEXUAL ORIENTATION/GENDER:

What is your sexual orientation?
- ☐ Heterosexual (straight)
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Other: _____

What is your gender?
- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Other: _____

ABUSE HISTORY:

As violence is a problem in many families, we ask these questions to ALL patients.

Verbal abuse:
- ☐ Currently experience
- ☐ Experienced in the past
- ☐ Never experienced
- ☐ Choose not to disclose

Physical abuse:
- ☐ Currently experience
- ☐ Experienced in the past
- ☐ Never experienced
- ☐ Choose not to disclose

Sexual abuse:
- ☐ Currently experience
- ☐ Experienced in the past
- ☐ Never experienced
- ☐ Choose not to disclose

ALCOHOL USE:

Do you drink? ☐ Yes ☐ No

If yes, how many per week?
Glasses of wine: _____
Cans of beer: _____
Shots of liquor: _____

RECREATIONAL DRUG USE:

Do you currently use? ☐ Yes ☐ No **Times per week?** _____

I use: *(Circle all that apply)*

Amphetamines	Amyl nitrate	Anabolic steroids	Barbituates	Benzodiazepines
"Crack" cocaine	Cocaine	Fentanyl	Flunitrazepam	GHB
Hashish	Ketamine	LSD	Marijuana	Ecstasy
Mescaline	Methamphetamines	Methaqualone	Methylphenidate	Nitrous oxide
Opiates	Opium	PCP	Psilocybin	Solvent inhalants

Other: _____

SEXUAL ACTIVITY/BIRTH CONTROL:

Sexually active?
- ☐ Yes
- ☐ No
- ☐ Not currently

Partners:
- ☐ Male
- ☐ Female
- ☐ Both

Birth control: *(circle all that apply)*

Abstinence	IUD	Vaginal condom
Birth control pills	Patch	Withdrawal
Cervical cap	Post-menopausal	None
Condom	Rhythm	Other: _____
Diaphragm	Spermicide	_____
Implant	Sponge	_____
Injection	Surgical	

TOBACCO USE:

Packs a day: *(Circle one)*
0.25 0.5 1 1.5 2 3

Smokeless tobacco? ☐ Yes ☐ No

Ready to quit? ☐ Yes ☐ No

Start date: _____

Quit date: _____

Comments: _____

_____

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ADVANCED DIRECTIVE:

I have:
- ☐ Living Will
- ☐ Durable Healthcare Power of Attorney
- ☐ None

Would you like information about the above?
☐ Yes ☐ No

NUTRITION:

Any unintended weight loss (more than 10 pounds in the past two months)?
☐ Yes ☐ No

VACCINES:

Have you ever had a pneumonia shot?
☐ Yes ☐ No

Have you had a flu shot this season?
☐ Yes ☐ No

MOBILITY:

Have you had any recent decline in mobility?
☐ Yes ☐ No

Have you had any recent changes in ability to perform activities of daily living?
☐ Yes ☐ No

Do you have a history of falls?
☐ Yes ☐ No

Assistive devices used: *(Circle all that apply)*

Brace LLE	Brace RLE	Cane	C-collar
Commode	Contacts	Crutches	Dentures
Eyeglasses	Other: _____		

COGNITIVE/FUNCTIONAL:

Are you deaf or hard of hearing?
☐ Yes ☐ No

Are you blind or have difficulty seeing, even wearing glasses?
☐ Yes ☐ No

Do you have dificulty concentrating, remembering or making decisions?
☐ Yes ☐ No

Do you have difficulty walking or climbing?
☐ Yes ☐ No

Do you have difficulty dressing or bathing?
☐ Yes ☐ No

Do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?
☐ Yes ☐ No

DEPRESSION SCREENING:

Over the past two weeks, have you often been bothered by:
- ☐ Little interest or pleasure in doing things
- ☐ Feeling down, depressed or hopeless
- ☐ None of the above

HOME CARE:

Current type of residence: *(Circle)*

Home alone	Home with family	Foster home
Group home	Assisted living	Nursing home
Skilled nursing facility	Other: _____	

Support systems: *(Circle all that apply)*

Spouse/significant other	Parent	Children	Family members
Case manager/social worker	Church/faith community		
Friends/neighbors	Home care staff	Organized support group	
Shelter	Therapist	None	Other: _____

Current assistance at home: *(Circle all that apply)*

Supervised setting	Home health care	Rehab	
Equipment	Educational support	ADL's	Medications
Respiratory care	In-home care giver	None	

Do you use home care services?
☐ Yes ☐ No ☐ Other: _____

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