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
- ☐ Eczema
- ☐ Endometriosis
- ☐ Eye disorders
- ☐ Fractures/broken bones
- ☐ Genital warts
- ☐ Gonorrhea
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Hives
- ☐ HPV
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ 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 disease
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcerative colitis
- ☐ Ulcers
- ☐ 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	Other cancer: ____	Diabetes	Drug dependency	Heart disease	High cholesterol	High blood pressure	Learning disabilities	Mental illness	Stroke	Sudden cardiac arrest	Brain tumor	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**

December 2016

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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: _____

Preferred Pronoun:
- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ 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	Barbiturates	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

Date of last Pap test: _____ **Normal:** ☐ Yes ☐ No

Date of last menstrual period: _____

Birth control: *(circle all that apply)*

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

TOBACCO USE:

☐ Yes ☐ No **Packs a day:** *(Circle one)*
0.25 0.5 1 1.5 2 3

Smokeless tobacco? ☐ Yes ☐ No

Start date: _____ **Quit date:** _____

Comments: _____

Ready to quit? ☐ Yes ☐ No

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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

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

NUTRITION:

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

VACCINE:

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

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 difficulty 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:
☐ Off campus with roommates ☐ Off campus without roommates
☐ On campus with roommates ☐ On campus without roommates

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: _____

List current medications (including birth control, over the counter medications, vitamins, etc.):

_____

_____

_____

_____

_____

_____

List allergies:

_____

_____

_____

_____

December 2016