Confidential Medical History Form

Name ______________________________ Date of birth ______________

Preferred/Chosen Name ______________________________

Have you EVER had any of the following?

Medical:

- ☐ ADD/ADHD
- ☐ Adrenal disorders
- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Bladder disease
- ☐ Bleeding disorder
- ☐ Borderline personality disorder
- ☐ Cancer
- ☐ Celiac disease
- ☐ Chicken pox
- ☐ Chlamydia
- ☐ Clotting disorder
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Endometriosis
- ☐ Eye disorders
- ☐ Fatigue
- ☐ Fractures
- ☐ Genital warts
- ☐ Gonorrhea
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Hives
- ☐ HPV
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irritable bowel syndrome
- ☐ Kidney stones
- ☐ Mononucleosis
- ☐ Malaria
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Muscular dystrophy
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Oppositional defiant disorder (ODD)
- ☐ Paget's disease of bone
- ☐ Pneumonia
- ☐ PCOS
- ☐ Pregnancy
- ☐ PTSD
- ☐ Psoriasis
- ☐ Radiation therapy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sinusitis (chronic)
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcerative colitis
- ☐ Ulcers

Anesthesia History:

- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Postoperative nausea and vomiting (PONV)
- ☐ Pseudocholinesterase deficiency
- ☐ Spinal headache

Surgical:

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Gall bladder
- ☐ Ear tubes
- ☐ Knee ACL tear
- ☐ Knee arthroscopy
- ☐ Organ transplant
- ☐ Ovarian cyst removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight loss surgery
- ☐ Other surgical history: ______________________________

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

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	Other health issues
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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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

ABUSE HISTORY:

As violence is a problem in many families, we ask these questions to ALL patients.
Please check all that apply.

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: *(Check all that apply)*

☐ Amphetamines	☐ Amylnitrate	☐ 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/method of contraception: *(Check 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:

Chewing Tobacco? ☐ Yes ☐ No

Cigarettes? ☐ Yes ☐ No

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

E-Cigarettes/Vape/Juul? ☐ Yes ☐ No

Cartridges/day: ___________

Start date: ___________

Quit date: ____________

Ready to quit? ☐ Yes ☐ No

SEXUAL ORIENTATION/GENDER:

What is your sexual orientation?
- ☐ Straight (not lesbian or gay)
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Don’t know
- ☐ Choose not to disclose
- ☐ Other: _________________

What is your gender?
- ☐ Female ☐ Male
- ☐ Transgender Female/Male-to-Female
- ☐ Transgender Male/Female-to-Male
- ☐ Choose not to disclose
- ☐ Other: _________________
- ☐ Cisgender Female
- ☐ Cisgender Male

Preferred Pronouns:
- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Theirs
- ☐ Other: _________________

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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

VACCINE:

Have you ever had a pneumococcal vaccine? ☐ Yes ☐ No

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

MOBILITY:

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

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

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

Assistive devices used: *(Check all that apply)*
☐ Contacts ☐ Eyeglasses ☐ Brace LLE ☐ Brace RLE ☐ Cane ☐ C-collar ☐ Commode
☐ Crutches ☐ Dentures ☐ Other: ________________________

COGNITIVE/FUNCTIONAL:

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

Are you blind or have difficulty seeing, even when 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:

Little interest or pleasure in doing things:
☐ Not at all ☐ More than half the days
☐ Several days ☐ Nearly every day

Feeling down, depressed or hopeless:
☐ Not at all ☐ More than half the days
☐ Several days ☐ Nearly every day

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

____

____

____

____

____

____

HOME CARE:

Current type of residence:
☐ Off campus with others ☐ Off campus alone
☐ On campus with others ☐ On campus alone

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 ☐ Shelter
☐ Organized support group ☐ Therapist ☐ None ☐ Other: __________

List allergies:

____

____

____

____

____

Do you speak any other languages besides English fluently?____

____

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