PROVIDENCE
Health & Services

PROVIDENCE MEDICAL GROUP AT PROVIDENCE ST. VINCENT
MEDICAL HISTORY FORM

NAME_____**AGE**_____ **TODAY'S DATE**_____

DATE OF BIRTH_____**PLACE OF BIRTH**_____

OCCUPATION_____

The information requested in this form is important for your care. If however, you are unsure or prefer not to answer, please leave it blank. You may choose to discuss it during your office visit.

Medical History – List disease or problem and approximate date of onset.	**List all surgeries including dates and doctors**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**
Medications/dosing/directions	**Hospitalizations/dates**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**
6.	**6.**
7.	**7.**
Are you allergic to: **Penicillin yes/no** **Sulfa yes/no** **Aspirin yes/no**	**Immunizations: Have you ever had the following and if so list date: Tetanus yes/no Date_____, Pneumovax yes/no Date_____, Flu shot yes/no Date_____**
Other medication allergies:	**When was your last:** **Complete physical**
1.	**Glucose/Cholesterol**
2.	**Flexible Sigmoidoscopy/colonoscopy**
3.	**EKG**
4.	**Mammogram**
5.	**Breast Exam**
Have you ever had a reaction to an immunization: Yes No	**Pap/Pelvic**

Has any blood relative ever had:
(circle one) yes/no relation

Breast cancer yes/no _____
Colon cancer yes/no _____
Other cancer yes/no _____
Tuberculosis yes/no _____
Diabetes yes/no _____
Glaucoma yes/no _____
Heart trouble yes/no _____
Hypertension yes/no _____
Stroke yes/no _____
Thyroid disease yes/no_____

Family History: Please give age if alive or age at time of death. Check ○ if deceased. List health problems:

Father ○

Mother ○

Siblings ○

Spouse ○

Children ○

Social History:

Yes/no Do you smoke?
Number of packs per day? _____
For how many years? _____

Yes/no Have you ever been a smoker?
How many years did you smoke? _____
When did you quit? Year_____

Yes/no Are you currently using chewing tobacco?

Yes/no Have you ever used IV drugs or Cocaine?

Yes/no Have you ever had blood transfusions?

Yes/no Do you drink alcohol daily?
Ounces/drinks per day? _____
How many years? _____

What are some of your hobbies?

List travel destinations outside of the U.S.

Marital status: married divorced single widowed

Sexual orientation? Heterosexual homosexual bixsexual

Yes/no Do you exercise regularly?

Menstrual history:
Date of last menstrual period:_____
Yes/no Are your periods regular?
Yes/no Are you pregnant?
Yes/no Are you breast-feeding?

<u>Have you ever had?</u>

yes/no Pneumonia
yes/no Tuberculosis
yes/no Hay Fever
yes/no Asthma
yes/no Heart attack
yes/no Heart disease
yes/no Rheumatic Fever
yes/no High blood pressure
yes/no Cancer
yes/no Diabetes
yes/no Bowel problems/colitis
yes/no Stomach disease/ulcer
yes/no Liver disease/jaundice
yes/no Gallbladder disease
yes/no Hemorrhoids
yes/no Gonorrhea
yes/no Syphilis
yes/no Herpes
yes/no Other venereal disease
yes/no Bladder disease
yes/no Kidney problems
yes/no Polio or Meningitis
yes/no Stroke
yes/no Hives/Eczema

<u>Have you had any of the following in the last 6 months?</u>

yes/no Shortness of breath
yes/no Wheezing/chronic cough
yes/no Chest pain
yes/no Heart palpitations
yes/no Difficulty walking
yes/no Blood in stools
yes/no Dark black stools
yes/no Abdominal pain
yes/no Anemia
yes/no Diarrhea/constipation
yes/no Problems urinating
yes/no Sexual dysfunction
yes/no Blood in the urine
yes/no 10lb loss in weight
yes/no Arthritis
yes/no Bone or joint disease
yes/no Any skin disease
yes/no Depression