ELITE HEALTHCARE CENTER

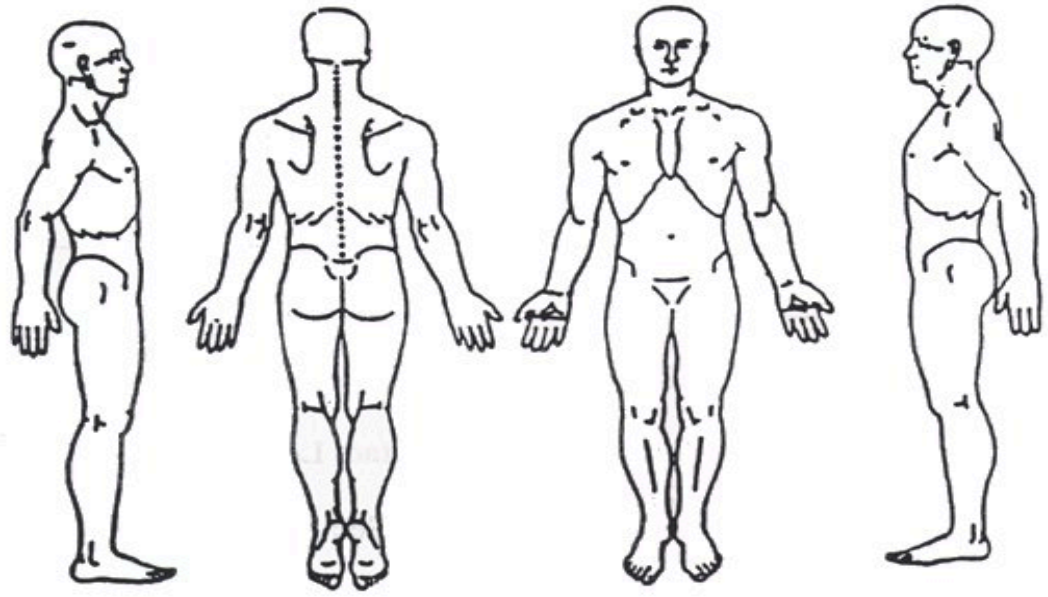
MEDICAL HISTORY FORM

(Please complete all **3** pages)

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

Chief Complaint: *(What brings you in today?)*	**Describe the pain:** *(stabbing, tingling, etc.)*
Onset: ☐ Sudden ☐ Built up over several days ☐ Gradual over a long time	
When did this problem start?	**Where did the injury occur?**

On the diagram below, please circle any area(s) of pain or discomfort.



Medications: (Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs)

Medication	Dose (mg)	Times per Day

Medication	Dose (mg)	Times per Day

Allergies or Reactions to Medicines/Foods/Other Agents:

Medication	Reaction or Side Effect

Personal Medical History: (Please indicate whether you have had any of the following medical problems – with approximate date of illness or diagnosis)

_____ Congenital Heart Diseases
Specify Type: _____
_____ Myocardial Infarction (Heart Attack)
_____ Hypertension (High Blood Pressure)
_____ Renal Failure
_____ High Cholesterol
_____ Thyroid Problem
Specify Type: _____
_____ Stroke
_____ Other: _____

_____ Cancer (Malignancy)
Specify Type: _____
_____ Coagulation (Bleeding/Clotting Disorder)
_____ Depression/Suicide Attempt
_____ Diabetes
_____ Gout
_____ Blood Transfusion
Specify Date: _____
_____ HIV/AIDS
_____ Other: _____

Surgical History: (Please list all prior operations and dates)

Operation	Date	Operation	Date

Women's Gynecologic History:

Are you now or could you become pregnant? ☐ **YES** ☐ **NO**
Can you become pregnant? ☐ Yes ☐ No If no, why? _____
Was your last period normal? ☐ Yes ☐ No Date: _____
Was your last mammogram normal? ☐ Yes ☐ No Date: _____
Was your last pap smear normal? ☐ Yes ☐ No Date: _____

Social History

Substances

Tobacco Use

☐ Cigarettes: Current Smoker, ____ Packs/Day, # of Years ____
☐ Quit, Date _____ ☐ Never
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes: #/week___
Is alcohol use a concern for you? ☐ No ☐ Yes

Drug Use

Do you use any recreational drugs? ☐ No ☐ Yes
Have you ever used needles? ☐ No ☐ Yes
Exercise: Do you exercise regularly? ☐ No ☐ Yes

SOCIOECONOMICS:

Occupation: _____

Education completed: ☐ Grade school ☐ High school
☐ College ☐ Graduate school
Years of education ____

Marital status: ☐Single ☐M ☐Sep ☐D ☐W ☐Co-habiting
☐Engaged...☐Other: _____

Spouse/Partner's name: _____
Number of children: _____
Who lives at home with you?_____

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

Other concerns?_____
_____

SAFETY:

Do use seatbelts consistently? ☐ No ☐ Yes
Do you use a bike helmet regularly? ☐ NA ☐ No ☐ Yes
Is violence at home a concern for you? ☐ No ☐ Yes
Do you feel safe in your current relationship? ☐ NA ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes

Other concerns?_____
_____

Family History: (Please indicate with a (X) family members who have had any of the following conditions)

Medical Condition	Mom	Dad	Sist	Bro	Daug	Son	Other Close Relative
Genetic Diseases							
Glaucoma							
Hay Fever (Allergic Rhinitis)							
Hearing Problems							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High Cholesterol Hyperlipidemia							
Kidney Diseases							
Lupus (Systemic Lupus Erythematosis)							
Mental Retardation							
Migraine Headache							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid Disorders							

Medical Condition	Mom	Dad	Sist	Bro	Daug	Son	Other Close Relative
Alcoholism							
Anemia							
Anesthesia Problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding Problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, Skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy (seizures)							
Tuberculosis							
Other:							

REVIEW OF SYSTEMS: Please check (√) any <u>current</u> problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination
Eyes
___Change in vision
Ears/Nose/Throat/Mouth
___Difficult hearing/ringing in ears
___Problems with teeth/gums
___Hay fever/allergies
Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations

Chest (breast)
___Breast lump/discharge
Respiratory
___Cough/wheeze
___Difficulty breathing
Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea
Genitourinary
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems
Musculo-skeletal
___Muscle/joint pain

Skin
___ Rash or mole change
Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination
Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression
Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding
*Other (please specify)*_____
_____

AB 11/29/03

_____ _____

Patient Signature Date