Mercy

Patient Medical History Form

Name: _____

Referred By: _____ Primary Care Physician: _____

Medical History Have you ever had any of the following?

- ☐ Anemia
- ☐ Heart Disease/Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Bleeding Problems
- ☐ Blood Clots in Lungs/Legs
- ☐ Gall Bladder Disease
- ☐ Liver Disease/Hepatitis
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Pelvic Infections
- ☐ Arthritis
- ☐ Chicken Pox
- ☐ Epilepsy/Seizures
- ☐ Migraines
- ☐ Depression/ Anxiety
- ☐ Drug or Alcohol Problem
- ☐ Diabetes
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sickle Cell Disease
- ☐ Thyroid Problem
- ☐ Blood Transfusion
- ☐ Genetic Condition
- ☐ Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_____ _____ _____ _____

_____ _____ _____ _____

List any allergies to medications: _____ ☐ No Known Allergies

Surgical History Please list all surgeries with dates:

_____ _____

_____ _____

Obstetrical History/Adoption History

☐ Check here if you have never been pregnant ☐ Check here if you have adopted children and list names below.

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor diabetes, high blood pressure)	Name/Age

Gyn History

Age of first period ____
Age of last period ____
Cycle length: every _____ days
lasting _____ days

Periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ Not really bothersome

Flow is: ☐ Light ☐ Light to moderate ☐ Moderate to heavy ☐ Very heavy

Are you sexually active? ☐ Yes How often: _____ ☐ No ☐ virginal

Sexual preference: ☐ heterosexual ☐ homosexual ☐ bisexual

New partners? ☐ yes ☐ no

Number of lifetime partners ____

Method of Birth Control: ☐ condoms ☐ pills ☐ patch ☐ vaginal ring ☐ tubal/Essure ☐ IUD ☐ partner with vasectomy ☐ natural family planning ☐ Implanon ☐ none ☐ other_____

Have you ever had any of the following STDs? ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Syphilis ☐ Trichomonas ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Never had any

Have you ever had any of the following? ☐ Fibrocystic breasts ☐ Ovarian cysts ☐ Endometriosis ☐ Uterine fibroids

Date of last pap smear: _____ ☐ normal ☐ abnormal

Have you ever needed any of the following for an abnormal pap? ☐ Colposcopy ☐ LEEP/Laser/Conization ☐ Cryosurgery ☐ No

Date of last mammogram: _____ ☐ Normal ☐ Abnormal ☐ Never had one

Date of last bone density: _____ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had one

Date of last colonoscopy: _____ Any polyps found? ☐ Yes ☐ No ☐ Never had one

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Family History

Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative/Age at Diagnosis
☐ Breast cancer		☐ High blood pressure	
☐ Ovarian cancer		☐ Diabetes	
☐ Uterine cancer		☐ Heart Disease (heart attack, stroke, bypass surgery)	
☐ Colon cancer			

Social History

Alcohol use	☐ Yes	☐ No	If yes, drink(s) per day/week/month						
Tobacco use	☐ Yes	☐ No	If yes, pack(s) per day for ____ years						
Street drug use	☐ Yes	☐ No	Type and frequency						
Exercise	☐ Yes	☐ No	Type and frequency						
Caffeine	☐ Yes	☐ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week						
Sexual Abuse	☐ Yes*	☐ No	If yes, are you safe now?	☐ Yes	☐ No	Counseling?	☐ Yes	☐ No	
Physical Abuse	☐ Yes*	☐ No	If yes, are you safe now?	☐ Yes	☐ No	Counseling?	☐ Yes	☐ No	
Emotional Abuse	☐ Yes*	☐ No	If yes, are you safe now?	☐ Yes	☐ No	Counseling?	☐ Yes	☐ No	

* Please let us know the type of abuse you are experiencing:

☐ pushed, slapped, choked, or kicked you ☐ smashed or thrown things ☐ made threats to you

☐ put you down ☐ humiliated you ☐ forced you to have sexual contact ☐ withheld money or medication

☐ other: _____

Review of Systems

Do you currently have any of the following?

		Comments			Comments
☐ Y ☐ N	Generally healthy	_____	☐ Y ☐ N	Frequent urination	_____
☐ Y ☐ N	Recent weight gain or loss of 25 lbs.	_____	☐ Y ☐ N	Burning with urination	_____
			☐ Y ☐ N	Incontinence	_____
☐ Y ☐ N	Fever	_____	☐ Y ☐ N	Urgency	_____
☐ Y ☐ N	Vision problems (excluding glasses)	_____	☐ Y ☐ N	BLadder infection	_____
			☐ Y ☐ N	Stomach pains	_____
☐ Y ☐ N	Sinus problems	_____	☐ Y ☐ N	Vaginal discharge	_____
☐ Y ☐ N	Hearing loss	_____	☐ Y ☐ N	Irregular vaginal bleeding	_____
☐ Y ☐ N	Chest pain	_____	☐ Y ☐ N	Pelvic pain	_____
☐ Y ☐ N	Varicose veins	_____	☐ Y ☐ N	Painful intercourse	_____
☐ Y ☐ N	Shortness of breath	_____	☐ Y ☐ N	Breast lumps	_____
☐ Y ☐ N	Chronic cough	_____	☐ Y ☐ N	Back pain	_____
☐ Y ☐ N	Diarrhea	_____	☐ Y ☐ N	Joint/muscle pain	_____
☐ Y ☐ N	Constipation	_____	☐ Y ☐ N	Depression/anxiety	_____
☐ Y ☐ N	Blood in stools	_____	☐ Y ☐ N	Fatigue	_____
☐ Y ☐ N	Heartburn/reflux	_____	☐ Y ☐ N	Sleep problems	_____
☐ None of the above			☐ Y ☐ N	Lack of libido	_____
			☐ None of the above		

Patient Signature _____ Date:_____

Clinician Signature _____ Date: _____

Annual Review #2 Clinician Signature. _____ Date: _____

Annual Review #3 Clinician Signature. _____ Date:_____

Patient Information

Date: _____

Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birthdate: _____ State of Birth: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: _____ Mother's Maiden Name: _____

Occupation: _____

Employer: _____

Employer Phone: _____

Insured Name: _____

Retirement Date: _____

Insured Birthdate: _____ SS#: _____

Insured Employer: _____

Phone Numbers: Home: _____ Work: _____ Ext.: _____

Cell: _____ e-mail: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home: _____ Work: _____ Ext.: _____

Do you have an advanced beneficiary (living will)? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Reason for visit: _____

_____

When did your symptoms appear? _____

Do you have any questions/concerns regarding your nutrition? ☐ Yes ☐ No

If yes, please list: _____

_____

Have you gained or loss more than twelve pounds unexpectedly within the last 6 months? ☐ Yes ☐ No