Medical Surgical Wellness Center **Comprehensive Medical History Form**

Name: ____ DOB: __________ Age: ______ Date: ____________

Your answers on this form will help Dr. Streeter understand your medical concerns and conditions. If you are a current patient, there is a shorter update form you can use. Please fill in all **four** pages. It is long because it is comprehensive. We want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. Thank you!

Who referred you to MSWC?

Circle one: Patient / family member / friend / Physician Name?______________________________

Main reason for today's visit:____

Other concerns: ____

My Health Care Goals:

____

MEDICATIONS: Prescription and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Aspirin, Advil, Aleve, Tylenol, etc.)

☐ Check box if you do not take any prescription or over the counter medications.

☐ Check box if you brought a list of your medications (give to Dr. and don't write any medications below)

Medication	Dose	Times per day	Medication	Dose	Times per day

ALLERGIES TO MEDICINES/FOODS/OTHER AGENTS: ☐ I am not allergic to any medications

Medication	Reaction	Medication	Reaction

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _______________ Results, if known__________________________

Sigmoidoscopy or Colonoscopy Date ____________Abnormal? ☐ No ☐ Yes Polyp Present? ☐ No ☐ Yes

WOMEN ONLY:

Mammogram Date/where ____Abnormal? ☐ No ☐ Yes

Pap Smear Date/where ____Abnormal? ☐ No ☐ Yes

Pelvic Ultrasound Date/where ____Abnormal? ☐ No ☐ Yes

Bone Density Test Date/where ____Abnormal? ☐ No ☐ Yes

Hysterectomy Date/where ____ ☐ Partial ☐ Total

Total # of pregnancies: ______ # of births: ______ # of miscarriages: ______ # of abortions: ______

Age at beginning of periods (menstruation): _______

Age at end of periods (menopause/hysterectomy): _________ ☐ Not applicable

If you are having periods, how often do they occur? Every ____ days. How long do they last? _____ days.

Date of Last Menstrual Period: __________________

☐ Abnormal bleeding between cycles

☐ Pelvic Inflammatory disease

☐ Endometriosis

☐ Fibroids

☐ Vaginal Discharge

☐ Heavy bleeding during period

☐ Vaginal Warts

☐ Nipple Discharge

☐ Ovarian Cysts

☐ Breast lump

☐ Breast pain

PERSONAL MEDICAL HISTORY:

Please check all conditions you currently have or have had.

- ☐ **Leave box blank if you have NO history of significant medical illnesses.**

Head
- ☐ Trauma

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wears glasses/contacts

Ears
- ☐ Hearing Aids
- ☐ Hearing Loss
- ☐ Ringing in Ears

Nose/Sinuses
- ☐ Allergic rhinitis (allergies)
- ☐ Nosebleeds
- ☐ Sinus Infections

Mouth/Throat/Teeth
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Gum Problems

Cardiovascular
- ☐ Aneurysm
- ☐ Angina (Chest Pain)
- ☐ Aortic Stenosis
- ☐ Arrhythmia
- ☐ DVT
- ☐ Hypertension
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Heart attack
- ☐ Other Heart Disease (specify______________)
- ☐ Palpitations

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD (Emphysema)
- ☐ Cough/Wheeze
- ☐ Difficulty breathing
- ☐ Pneumonia

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Bloody/Black Stool
- ☐ Bowel Irregularity
- ☐ Cirrhosis
- ☐ Constipation
- ☐ Diarrhea/Nausea/Vomiting
- ☐ Diverticulitis
- ☐ Fatty Liver
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia (specify type_______)
- ☐ Jaundice
- ☐ Ulcer

General
- ☐ Obesity
- ☐ Weight loss
- ☐ Weight gain

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty starting urination
- ☐ Discharge from penis
- ☐ Elevated PSA
- ☐ Incontinence
- ☐ Kidney stones/disease
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Painful urination
- ☐ Prostate Enlargement
- ☐ Sexual function problems
- ☐ STD (specify_____________)
- ☐ UTI (s)

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain
- ☐ Fibromyalgia
- ☐ Fractures (location___________)
- ☐ Gout
- ☐ Joint pain/swelling
- ☐ Joint replacement (location___________)

Skin
- ☐ Dermatitis
- ☐ Fungal infections
- ☐ Mole (s)
- ☐ Other skin condition(s) (___________)
- ☐ Psoriasis

Neurological
- ☐ Dizziness/Light-headedness
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Loss of coordination
- ☐ Memory Loss
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke

Psychiatric
- ☐ Anxiety/Stress
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Hallucinations, delusions
- ☐ Suicidal Ideation
- ☐ Suicide attempts

Endocrine
- ☐ Goiter
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypothyroidism
- ☐ Thyroid Disease
- ☐ Thyroiditis
- ☐ Type 1 Diabetes Mellitus
- ☐ Type 2 Diabetes Mellitus

Heme/Oncology/Lymphatic
- ☐ Anemia
- ☐ Bleeding problem (________)
- ☐ Cancer (specify type _____________)
- ☐ Cellulitis
- ☐ Lymphedema

Infectious
- ☐ HIV
- ☐ STD
- ☐ Tuberculosis

Auto-Immune
- ☐ Lupus

SURGICAL & PROCEDURE HISTORY (please list all prior operations and dates):

☐ I have had no prior surgery.

Operation	Date	Operation	Date

FAMILY HISTORY

Please check the type of disease or illness that the family member has had or now has. *Please specify the number of siblings/children if applicable.

☐ I do not know my family history.

Family Member	Mother	Father	*Sister(s)	*Brother(s)	*Daughter(s)	*Son(s)	Was this the cause of death?
Alive							
Deceased							
Age currently or at death							
No health concern							
Alzheimer's							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer_________________							
CHF							
COPD							
Diabetes Mellitus							
Heart Attack							
Heart Disease							
Hypertension							
High Cholesterol							
Kidney Disease							
Mental Illness							
Osteoporosis/Osteopenia							
Stroke							

SOCIAL HISTORY

Tobacco Use:
- ☐ I have never smoked
- ☐ Current smoker:

pack(s)/day ______ # of years: ______
- ☐ Former smoker: Quit Date:________

Approximately how many packs/day did you smoke? _____
How many years did you smoke?_____
Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use:
Do you drink alcohol?
☐ Never ☐ Occasionally ☐ Regularly
drinks/week: ___________
☐ Beer 12 oz. ☐ Wine 5 oz. ☐ Liquor 1.5 oz

Drug Use:
Have you **ever** used recreational drugs? ☐ No ☐ Yes
If yes, which ones ___________________________
Quit which ones? All ☐ ________________________
Any used currently? __________________________

Sexual Activity:
Sexually active? ☐ Never ☐ Yes ☐ Not currently
Current sexual partner(s) is/are: ☐ Male ☐ Female

Contraception and Protection:
Birth control method (check all that apply):
- ☐ None needed
- ☐ Condom
- ☐ Pill
- ☐ IUD

Please continue to next column on right

- ☐ Patch
- ☐ Ring
- ☐ Diaphragm
- ☐ Vasectomy
- ☐ Tubal Ligation
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Other: (specify:______________)

Exercise:
How active are you?
- ☐ I get a cardio workout 3 or more times/week.
- ☐ I exercise or walk less than 3 times/week.
- ☐ I work daily but do not work out
- ☐ I am not generally active.
- ☐ Other:____________________

Diet:
Do you follow a special diet? ☐ No ☐ Yes
Vegetarian, Vegan, Gluten-free, other _____
Do you drink coffee? ☐ No ☐ Yes
cups/day ________
Do you drink tea or pop? ☐ No ☐ Yes
cups/day ________

Other (ADL):
Exposure to toxic chemicals at work? ☐ No ☐ Yes
Exposure to blood or body fluids at work? ☐ No ☐ Yes

SOCIOECONOMICS:

Ethnic Background: How would you describe yourself? (check only one)
☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Native Hawaiian & other Pacific Islander
☐ White, Non-Hispanic ☐ Other ☐ Decline

Education:
☐ High school or GED ☐ Trade school ☐ College ☐ Graduate school ☐ Doctorate ☐ Other: ____________

Marital Status:
☐ Single ☐ Partner ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed