

CHI St. Joseph Medical Information Form

Date: _____

Patient Name: _____ DOB: _____

Medical History: (Please check if you have or had any of the following)

<input type="checkbox"/> Abuse (physical/mental/sexual/verbal, etc.)	<input type="checkbox"/> Cholesterol (high)	<input type="checkbox"/> Intestinal Disease
<input type="checkbox"/> Abnormal Pap	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Kidney or Bladder Problems
<input type="checkbox"/> Alcoholism/Drug use	<input type="checkbox"/> Depression/mental disorder	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety/nerves	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Serious Accident/Injury
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Genetic Diseases	<input type="checkbox"/> Sexual Disease/VD
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma/Cataract	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies	<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding disease	<input type="checkbox"/> Headaches/Migraine	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers/Stomach Disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Hepatitis (any)	
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> High blood pressure	

Do you have an advance directive on file? Yes No

OB/GYN History

Date of last pap smear: _____

Have you ever had an abnormal pap? Yes No If yes, date and results _____

Date of last mammogram: _____

Have you ever had an abnormal mammogram? Yes No If yes, date and results _____

History of hysterectomy? Yes No If yes, date and why? _____

Do you have an OB/GYN? Yes No If yes, then who? _____

Age of first period: _____ Date of last period: _____

Pregnancies: Total # ___ Full Term ___ Miscarriages ___ Abortions ___ Premature ___ Tubal ___

Complications: _____

Surgical History

Date or Age	Surgery

Hospitalizations

Date or Age	Reason/Details

Family History (place a checkmark where applicable)

	Alive (A) Deceased (D)	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness (Type?)	Cancer (Type?)	Unknown	Other
Father									
Mother									
Sibling(s)									
Son(s)									
Daughter(s)									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Paternal Uncle									
Paternal Aunt									
Maternal Uncle									
Maternal Aunt									

Other (please explain) _____

Social History

Are you a current smoker? Yes No If no, then have you ever smoked? Yes No

How many per day? _____ For how many years? _____

What year did you quit? _____ Are you interested in quitting? Yes No

Do you use other tobacco products, and if so, what? _____

Do you drink alcohol? Yes No How many drinks per day? _____ How many times a week? _____

Do you use any recreational drugs, and if so, what? _____

Have you ever had an alcohol or drug problem in the past? Yes No

Are you sexually active? Yes No Single Partner Multiple Partners

Any history of sexually transmitted infections, and if so, what? _____

Do you drink caffeine? Yes No How much per day? _____

Occupation: _____

Marital Status Single Married Divorced Widowed

Do you have children? Yes No What are their ages? _____

Social Functioning Assessment (Primary Care Visits Only)

1. During the past 4 weeks, was someone available if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself. Yes, as much as I wanted Yes, quite a bit Yes, some Yes, a little No, not at all I choose not to answer
2. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply) Yes, it has kept me from medical appointments or getting my medications. Yes, it has kept me from non-medical appointments, meetings, work, or getting things I need. No. I choose not to answer.

Additional Information

Any other family members attend our clinics, and if so, who? _____

Who was your prior primary care physician and location? When was your last visit?

What would you like to discuss with the physician today?

Current Medications (prescription, over-the-counter, vitamins, supplements, or herbals)

Medication Name	Dosage	How often?
Example: Name of drug	5 mg	One pill twice a day or one pill daily

Allergies (medications, x-ray dyes, other substances, seasonal, etc.)

Name of Substance	Reaction
Example: Name of drug	Hives, swelling

Health Maintenance/Screening/Special Tests (list the dates of your last studies/exams)

Study/Exam	Approximate Date/Year	Abnormal?
Physical/Annual exam		
Bone density test		
Colonoscopy		
EKG		
Stress test		
PSA (Prostate-specific antigen)		
Dental exam		
Eye exam		

Immunizations (list the dates when you received the vaccines)

Immunization	Approximate Date/Year
Flu	
Pneumonia	
Tetanus	
Tdap (tetanus plus whooping cough)	
Hepatitis B	
Gardasil	
Tuberculosis screening <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Shingles	

Would you be interested in receiving these today? Yes No

Review of Systems (Circle the items that you are **CURRENTLY** experiencing)

<p><u>General</u> Fever Chills Night sweats Weight loss Weight gain Fatigue</p> <p><u>Eyes</u> Vision changes Eye redness Eye drainage Eye pain Corrective lens</p> <p><u>Ear, Nose, & Throat</u> Hearing changes Ear pain Ear drainage Nasal congestion Runny nose Postnasal discharge Nose bleeds Sore throat Voice changes</p> <p><u>Cardiovascular</u> Chest pain Palpitations/heart racing Shortness of breath Shortness of breath when lying flat Swelling in the legs/feet Leg/foot pain Varicose veins</p> <p><u>Pulmonary</u> Shortness of breath at rest Shortness of breath with walking Cough Wheezing Snoring</p>	<p><u>Gastrointestinal</u> Abdominal pain Nausea Vomiting Heartburn/indigestion Difficulty/pain with swallowing Change in bowel movements Diarrhea Constipation Blood in the stool</p> <p><u>Male Genitourinary</u> Pain with urination Frequent urination Urgent need to urinate Abnormal urine stream Urinary incontinence Blood in the urine Erection problems Discharge from the penis</p> <p><u>Female Genitourinary</u> Pain with urination Frequent urination Urgent need to urinate Urinary incontinence Blood in the urine Vaginal discharge Pelvic pain Painful periods Irregular periods</p> <p><u>Musculoskeletal</u> Neck pain Back pain Joint pain Muscle pain</p>	<p><u>Integumentary</u> Rash Itching Dry/sensitive skin Breast masses/lumps Nipple discharge</p> <p><u>Neurological</u> Headache Dizziness Numbness Weakness Tingling Memory loss</p> <p><u>Psychiatric</u> Depression Anxiety Mania/euphoria Mood swings Hallucinations</p> <p><u>Endocrine</u> Excessive urination Excessive thirst/drinking Excessive hunger Feeling cold all the time Feeling hot all the time</p> <p><u>Hematology/Lymph</u> Swollen lymph nodes Excessive bruising Excessive bleeding Anemia History of transfusion</p> <p><u>Allergy/Immunology</u> Lip/facial swelling Hives Environmental allergies Seasonal allergies Food allergies</p>
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