Mesquite Employee Health Center

revised 10/23/2013

Medical History Form

Patient's Name: _____ Age: _____ DOB: _____Today's Date:_____

Marital Status:_____ # of children:_____ Occupation:_____Allergies:_____

(Staff only: Height: _____ Weight:_____ Blood pressure: _____) Times/

Past Medical History: Please Check (√) if you have ever had any of the following:

ADD/ADHD		Cancer (type_____)		High Cholesterol	
Alcohol/Drug Addiction		COPD/emphysema		Kidney Disease	
Allergies		Diabetes		Liver Disease	
AIDS/HIV		Epilepsy/Seizures		Mitral Valve Prolapse	
Anemia		Fractures (Location _____)		Psychiatric Disorders	
Anxiety		GI/Bowel Disease		Reflux (GERD)	
Arthritis		Glaucoma		Stroke	
Asthma		Heart Disease/ Attack		Syphilis	
Back Problems		Heart Murmur		Thyroid Disease	
Breast Disease		Hepatitis		Tuberculosis	
Depression		High Blood Pressure			

Medications	Dosage	Day

Women Only: History of Abnormal Pap smear? Yes No Have you ever had a colposcopy or cervical biopsy? Yes No History of HPV? Yes No

Any other GYN procedures? _____ Number of vaginal births: _____ Number of C-sections:_____

Have you ever had an abnormal mammogram? Yes / No Have you ever had a breast biopsy? Yes / No - Right breast/ Left Breast

Date of last cycle:_____ How often do you have your cycle?_____ How long does it typically last? _____

Do you use any form of birth control? _____ (Staff Only G:_____ FT:_____ PT: _____ SA:_____ IA:_____ LB:_____)

Past Surgical History: if you have had any of the following, please give the year the procedure was performed:

Removal of Tonsils		Removal of Skin Cancer		Eye surgery		Back Surgery	
Removal of Adenoids		Removal of Gall Bladder		Cosmetic Surgery		Neck Surgery	
Removal of Appendix		Sinus Surgery		Repair of Fractured Bone		Pace Maker/ Defibrillator	
Removal of Uterus		Removal of Ovaries		Tubal Ligation		Vasectomy	

Please list dates of any other surgeries, hospitalizations or major illnesses:_____

_____

Family History: Please list which family members have the following medical history:

Alcohol/Drug Addiction	(i.e. mom)	Diabetes		High Cholesterol	
Anxiety		Epilepsy/Seizures		Kidney Disease	
Arthritis		GI/Bowel Disease		Liver Disease	
Asthma		Glaucoma		Stroke	
Breast Disease		Heart Disease/ Attack		Thyroid Disease	
Depression		High Blood Pressure		Cancer (type_____)	

Social History: Are you a current smoker? Y/N How long does a pack last? _____ How many years have you been smoking?___

Past smoker? Y/N What year did you quit? _____ How many years did you smoke for? _____ How much did you smoke? _____

Do you use any form of smokeless tobacco? Y/ N How long does a can last? _____

How often do you have alcohol? _____ Have you ever used recreational drugs? Y/ N _____

Review of Systems: Please check (√) if you have been experiencing any of the following symptoms:

Chest Pain		Constipation		Depressed or Anxious Mood		Persistent Cough	
Heart Palpitations		Black or Bloody Stools		Ears Ringing		Heart Burn	
Shortness of Breath		Problems with urination		Blurry Vision		Skin Rashes	
Stomach Pain		Joint/Muscle Pains		Dizziness		Unusual Moles	
Vomiting		Unintentional Weight Loss		Weakness		Swollen Ankles/Feet	
Diarrhea		Night Sweats		Headaches			

Date of your last colonoscopy: _____ Date of your last eye exam: _____ Date of your last dental exam: _____

Date of your last Tetanus Vaccine: _____ For 60yo and up, Shingles Vaccine:_____ For 65 and up Pneumonia Vaccine: ____

Patient Signature: _____ Date: _____ Provider initials: _____