CHI St. Joseph Medical Information Form

Date:_____

Patient Name:_____ DOB:_____

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

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

Would you be interested in receiving these today? ☐ Yes ☐ No

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

General
Fever
Chills
Night sweats
Weight loss
Weight gain
Fatigue

Eyes
Vision changes
Eye redness
Eye drainage
Eye pain
Corrective lens

Ear, Nose, & Throat
Hearing changes
Ear pain
Ear drainage
Nasal congestion
Runny nose
Postnasal discharge
Nose bleeds
Sore throat
Voice changes

Cardiovascular
Chest pain
Palpitations/heart racing
Shortness of breath
Shortness of breath when lying flat
Swelling in the legs/feet
Leg/foot pain
Varicose veins

Pulmonary
Shortness of breath at rest
Shortness of breath with walking
Cough
Wheezing
Snoring

Gastrointestinal
Abdominal pain
Nausea
Vomiting
Heartburn/indigestion
Difficulty/pain with swallowing
Change in bowel movements
Diarrhea
Constipation
Blood in the stool

Male Genitourinary
Pain with urination
Frequent urination
Urgent need to urinate
Abnormal urine stream
Urinary incontinence
Blood in the urine
Erection problems
Discharge from the penis

Female Genitourinary
Pain with urination
Frequent urination
Urgent need to urinate
Urinary incontinence
Blood in the urine
Vaginal discharge
Pelvic pain
Painful periods
Irregular periods

Musculoskeletal
Neck pain
Back pain
Joint pain
Muscle pain

Integumentary
Rash
Itching
Dry/sensitive skin
Breast masses/lumps
Nipple discharge

Neurological
Headache
Dizziness
Numbness
Weakness
Tingling
Memory loss

Psychiatric
Depression
Anxiety
Mania/euphoria
Mood swings
Hallucinations

Endocrine
Excessive urination
Excessive thirst/drinking
Excessive hunger
Feeling cold all the time
Feeling hot all the time

Hematology/Lymph
Swollen lymph nodes
Excessive bruising
Excessive bleeding
Anemia
History of transfusion

Allergy/Immunology
Lip/facial swelling
Hives
Environmental allergies
Seasonal allergies
Food allergies