SUMMA HEALTH CARE

# Medical History Form

Name: _____
Date: _____

What do you prefer to be called (nickname)? _____

**Medical History:** Have you ever been treated for any of the following medical conditions?

☐Arthritis
☐High Blood Pressure
☐ Irritable Bowel Syndrome
☐ Lung Problems
☐Osteoporosis
☐Cancer
☐Thyroid Problems
☐Depression/Anxiety
☐Heart Problems
Please list any additional medical problems:
_____
_____
☐Diabetes
☐High Cholesterol
Have you ever had any surgeries? ☐Yes ☐No
Have you ever been hospitalized overnight?: ☐Yes ☐No

**Family History**: Please list any known medical problems for the relatives listed below: *(For example: diabetes, breast/colon/ovarian/prostate/skin cancer, heart attacks/heart murmur, high blood pressure, high cholesterol, alcohol/drug abuse, depression, osteoporosis, etc)*

*(circle one)*
Mother: _____ Living/deceased
Father: _____ Living/deceased
Brother/Sister: _____Living/deceased
Son/Daughter: _____Living/deceased
Aunt/Uncle: _____ Living/deceased
Maternal Grandma/Grandpa:_____ Living/deceased
Paternal Grandma/Grandpa: _____ Living/deceased
Describe your eating habits:
(poor/well-balanced/vegan/vegetarian/gluten-free/etc):
_____

***Habits:***
What do you do for exercise? _____
How often do you exercise? _____
Tobacco?(Chew/Smoke/Never smoked): _____Packs a day?
Alcohol (beer/wine/Liquor/etc): _____Daily?
Street Drugs (Meth, Cannabis, etc):_____
How often do you do street drugs?_____
Caffeine (coffee/tea/soda/energy drink/other): ____ Daily?
Do you have trouble sleeping? ☐Yes ☐No ☐Sometimes
Do you eat out more than twice a week? ☐Yes ☐No

**Relationship Status**: ☐Single ☐Married ☐ Divorced ☐ Separated ☐Widow ☐ Civil Union ☐Lives Alone How long? _____
Who do you live with? _____
How many adults live with you? _____
How many children live with you? _____
How many pets do you own? _____
What kind of pets do you have? _____
Others that live with you? (circle one):
Parents/Siblings/Foster Children/Friends
What type of housing do you have? (Circle one): Homeless/ Rent/Shelter/Own home/Live with relatives/Lives with parents

Have you traveled outside the US in the last 6 months? ☐Yes ☐No If yes where did you travel to? _____
Do you have smoke detectors in you home? ☐Yes ☐No
Any legal issues? (circle one) Parole, Probation, Awaiting trial, None
Who would your support system be? (Circle one) Relies on family, friends, government assistance

**Social History:**
Employment Status? _____
Are you retired? ☐Yes ☐No
Occupation: _____ Do you enjoy your job? ☐Yes ☐No ☐Sometimes
Any major stresses in your life? _____
Religious Preference? _____
Involved in any community involvements? ☐Yes ☐No
If yes what? _____
Do you wear a seatbelt? ☐Yes ☐No ☐Sometimes
Do you have an eye exam at least every two years? ☐Yes ☐No ☐Sometimes
Do you have a dental exam yearly? ☐Yes ☐No ☐Sometimes
Race:_____ Ethnicity: _____
Preferred Language: _____

Do you have an Advance Directive (Living Will/DNR/etc)? ☐Yes ☐No If yes what do you have? _____
When was it made? _____
Number of pregnancies/children do you have: _____
Boy(s)_____ Girl(s): _____
Healthy: ☐ Yes ☐No if not healthy why? _____
How many children are deceased? _____
Do your children have any behavioral issues at home or in school? ☐Yes ☐No
How many siblings Do you have? _____ Brother(s) _____
Sister(s) _____
Healthy ☐Yes ☐No How many deceased? _____
Are you sexually active? ☐Yes ☐No
Sexually active in the last 12 months? ☐Yes ☐No

SUMMA HEALTH CARE

# Medical History Form

Name: _____
Date: _____

Do you prefer only ☐Men ☐Women ☐Both
What kind of protection do you use? ☐Condoms ☐Birth Control ☐ Other_____
Are you transgender ☐ Yes ☐ No
Have you ever had an STD? ☐Yes ☐No
If yes what do/did you have_____
Are you having sexual problems currently? ☐Yes ☐No
Is your relationship monogamous? ☐Yes ☐No

Do you use protection? ☐Yes ☐ No ☐ Sometimes
Do you currently have more than one partner? ☐Yes ☐No
Do you feel you ever have been abused (circle all that apply) (verbally/physically/mentally/sexually)? ☐Yes ☐No ☐Sometimes ☐In the past
Do you feel like where you are living is not safe? Like your life is in danger? ☐Yes ☐No

**Patient Signature: _____**

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## ***The following section will be completed and used by clinic staff only***

**Prevention**

**Women:**
Chlamydia Screening: _____
Bone Density: _____
Last Pap Smear Test_____
Last Mammogram_____
Date of last Menstrual Cycle: _____
Was it: Regular/Irregular, Heavy/Light/Spotted, Painful/not painful
How many days did it last usually? ____
Hysterectomy: ☐Full ☐Partial ☐N/A

**Men:**
PSA Screening: _____

**Everyone:**
Colonoscopy: _____Pylops? Y/N +/-
Endoscopy: _____Result?_____
Lipid Panel: _____
Fasting Glucose: _____HgbAic:_____

**Immunizations:**
Tdap:_____ Zostavax: _____
Pneumovax: _____ Influenza: _____
Gardasil:_____Other:_____