Maple Street Medical Group

Patient History Form

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

ALLERGIES

Are you allergic to any drugs or food? ☐ Yes ☐ No (*Please list below*)

Name of Food or Drug	Reaction	Name of Food or Drug	Reaction

PAST MEDICAL HISTORY – Have you *ever* had any of the following: *Please check all that apply.*

Height _____ ft. _____ in. **Weight** _____ lbs.

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Osteoarthritis
- ☐ Blood Clots/DVT
- ☐ Clotting Disorder
- ☐ Bowel Disorder
- ☐ Cancer _____
- ☐ Congestive Heart Failure
- ☐ Chronic Low Back Pain
- ☐ Diabetes ☐ 1 ☐ 2
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Fractures _____
- ☐ Gallbladder Problems
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis /Liver Problems
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disorders
- ☐ Memory Trouble
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Reflux
- ☐ Respiratory Disorders
  - ☐ *Asthma* ☐ *Bronchitis*
  - ☐ *COPD* ☐ *Emphysema*
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Skin Problems/Disorders
- ☐ STD's i.e. herpes
- ☐ Thyroid Disorders
- ☐ Ulcer
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

IMMUNIZATION HISTORY – Have you had:

Hepatitis B: □ Yes □ No When?_____ Tetanus: □ Yes □ No When?_____

Pneumovax Immunization: □ Yes □ No When?_____ HPV: □ Yes □ No When?_____

Flu Immunization: □ Yes □ No When?_____ Other: □ Yes □ No When?_____

EXAM HISTORY – When was your last:

Pap smear: _____ Colonoscopy: _____ Stool check for blood: _____

Mammogram: _____ Prostate Exam: _____ Cholesterol Check: _____

PAST SURGICAL/HOSPITALIZATION HISTORY *Please include all including childhood surgeries.*

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY MEDICAL HISTORY *Check problem and indicate who was diagnosed:* ***Mother = M, Father = F, Sibling = S, Grandparent =G***

Disorder	Who	Disorder	Who
☐ Anemia	☐ M ☐ F ☐ S ☐ G	☐ High Blood Pressure	☐ M ☐ F ☐ S ☐ G
☐ Arthritis	☐ M ☐ F ☐ S ☐ G	☐ Kidney Disorders	☐ M ☐ F ☐ S ☐ G
☐ Blood Clots	☐ M ☐ F ☐ S ☐ G	☐ Mental Illness	☐ M ☐ F ☐ S ☐ G
☐ Clotting Disorder	☐ M ☐ F ☐ S ☐ G	☐ Migraines	☐ M ☐ F ☐ S ☐ G
☐ Bowel Problems/Disorders	☐ M ☐ F ☐ S ☐ G	☐ Osteoporosis	☐ M ☐ F ☐ S ☐ G
☐ Cancer	☐ M ☐ F ☐ S ☐ G	☐ Respiratory Disorders	☐ M ☐ F ☐ S ☐ G
☐ Congestive Heart Failure	☐ M ☐ F ☐ S ☐ G	☐ Seizures	☐ M ☐ F ☐ S ☐ G
☐ Diabetes	☐ M ☐ F ☐ S ☐ G	☐ Stroke	☐ M ☐ F ☐ S ☐ G
☐ Depression	☐ M ☐ F ☐ S ☐ G	☐ Substance Abuse	☐ M ☐ F ☐ S ☐ G
☐ Fibromyalgia	☐ M ☐ F ☐ S ☐ G	☐ Thyroid Disorders	☐ M ☐ F ☐ S ☐ G
☐ Heart Disease	☐ M ☐ F ☐ S ☐ G	☐ Ulcer	☐ M ☐ F ☐ S ☐ G
☐ High Cholesterol	☐ M ☐ F ☐ S ☐ G	☐ Other: _____	

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SOCIAL HISTORY

Your Occupation: _____ **Place of employment:** _____

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Student

Have you ever worked with hazardous material? ☐ Yes ☐ No

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____

Significant Other's Name: _____

Are you sexually active with: ☐ Men ☐ Women ☐ Both

Do you drink caffeine? ☐ Yes ☐ No **How many cups per day?** _____

Do you drink alcohol? ☐ Yes ☐ No

Type: ☐ Beer ☐ Wine ☐ Mixed Drinks

No. drinks: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ **Per**: ☐ Day ☐ Week ☐ Mo.

Have you ever had a problem with alcohol? ☐ Yes ☐ No

Do you currently use any recreational drugs? ☐ Yes ☐ No

☐ If yes, which ones? _____

Do you use tobacco? ☐ Yes ☐ No ☐ Quit Date: _____ **Type of tobacco**: ☐ Cigarettes ☐ Cigars ☐ Chew

Cigarette Packs/day: ☐ ¼ ☐ ½ ☐ 1 ☐ 1-2+ **Total length of use (in years):** _____ **Ever been a smoker**: ☐ Yes ☐ No

Do you feel physically or sexually threatened at home? ☐ Yes ☐ No

Do you have any safety concerns? ☐ Yes ☐ No

GYNECOLOGICAL & OBSTETRICAL HISTORY

How many pregnancies? _____ Full term births: _____ Miscarriages: _____

Ectopic Pregnancies: _____ Elective Abortions: _____ C-Sections: _____

Children 's Names & Year of Birth: _____

1st Day of last period: _____ How many days between periods? _____

How long does your period last? _____ Age of onset of periods: _____

Tampons per 24 hours: _____ Pads per 24 hours: _____

Age of Menopause Onset: _____

Bleeding between periods: ☐ Yes ☐ No (*please describe*): _____

Cramps: ☐ Yes ☐ No (*please describe*): _____

Postmenopausal bleeding: ☐ Yes ☐ No (*please describe*): _____

Have you ever been sexually active? ☐ Yes ☐ No **Are you currently sexually active?** ☐ Yes ☐ No

Number of partners in the last year: _____

How long with current partner: _____

Condom use % of the time: _____

Birth Control method (if appropriate): _____

Pain during intercourse: ☐ Yes ☐ No (*please describe*): _____

Bleeding after intercourse: ☐ Yes ☐ No (*please describe*): _____

History of uterine tumor: ☐ Yes ☐ No (*please describe*): _____

History of ovarian cyst: ☐ Yes ☐ No (*please describe*): _____

History of Abnormal pap smear: ☐ Yes ☐ No (*please describe*): _____

Urine incontinence other: ☐ Yes ☐ No (*please describe*): _____

Any sexual health concerns: ☐ Yes ☐ No (*please describe*): _____

History of STDs: ☐ Yes ☐ No (*please describe*): _____