PATIENT INFORMATION AND MEDICAL HISTORY

Patient Name____________________
SSN____________________________
Birth date______________________
Phone Number
____

Indiana University Health

THE FOLLOWING INFORMATION IS CONFIDENTIAL.

History

List all Medications which you currently use and why:
(ex. Insulin for Diabetes, Motrin for Arthritis, etc...)

☐ NONE

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

If you have any allergies, please list them and your reaction here:
(ex. Eggs-rash, Penicillin-short of breath, Dust-congestion, etc...)

☐ NONE

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________

PAST MEDICAL HISTORY

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD,
(Please provide details for *all "Yes"* responses in the comment section below)

Yes	No		Yes	No	
___	___	BONE OR JOINT PROBLEMS	___	___	IRREGULAR HEART BEAT
___	___	EPICONDYLITIS	___	___	CHEST PAIN
___	___	ARTHRITIS	___	___	CORONARY ARTERY DISEASE
___	___	CARPAL TUNNEL SYNDROME	___	___	HEART ATTACK
___	___	FREQUENT BACK PROBLEMS OR PAIN	___	___	LIVER PROBLEMS
___	___	ASTHMA	___	___	KIDNEY PROBLEMS
___	___	BRONCHITIS	___	___	ANY NERVE DISORDER
___	___	TUBERCULOSIS	___	___	MENTAL DISORDERS
___	___	POSITIVE TB SKIN TEST	___	___	BLACKOUTS OR FAINTING
___	___	PNEUMONIA	___	___	SEIZURES, EPILEPSY
___	___	EMPHYSEMA	___	___	CANCER
___	___	CHRONIC COUGH	___	___	THYROID DISEASE
___	___	TRAUMATIC CHEST INJURY	___	___	ULCERS, INTESTINAL PROBLEMS
___	___	DIABETES	___	___	VASCULAR DISEASE
___	___	PERSISTANT SKIN RASH	___	___	HYPERTENSION, (HIGH BLOOD PRESSURE)
___	___	ECZEMA, SKIN ALLERGIES	___	___	STROKE
___	___	HAYFEVER	___	___	SENSITIVITY TO CHEMICALS OR DUST
___	___	ANEMIA, OR BLEEDING DISORDER	___	___	ANY PERMANENT RESTRICTIONS DUE TO A MEDICAL CONDITION
___	___	PPI RATING OR DISABILITY RATING	___	___	ANY OTHER CONDITION NOT LISTED

COMMENTS:

Please list all surgeries or hospitalizations and date:
(ex. appendectomy 1996, lumbar disc 1994, etc..)
1.____
2.____
3.____
4.____

Comments:

Prevention

Tobacco History
Cigarettes/cigars/pipe/chewing/snuff:
(Circle the form of tobacco you use)

Never smoked/used tobacco ________
Started using tobacco in the year ________
Quit using tobacco in the year ________
Average packs/day smoked ________
Number of tins/pouches/week ________

Alcohol History

_____Never Drink
_____Used to drink but stopped in the year_____
_____Drink occasionally
_____Have about one drink/day
_____Have more than one drink/day on average
_____Have more than 14 drinks/week on average

Do you wear seat belts? Y N
Do you exercise regularly? Y N
Do you get overly short of breath or experience chest pain with exertion? Y N
Have you ever had a colonoscopy? Y N

Has your cholesterol been checked in the last 5 years? Y N
Have you had a tetanus booster within the last 10 years? Y N
Have you had the Hepatitis B vaccine series? Y N
Do you receive yearly flu shots? Y N
Have you ever had a pneumonia shot? Y N

Comments____

Family History

Has any blood relative in your family, (ie. grandparents, parents, brothers, sisters, etc...) ever had any of the following diseases, if so please indicate:

	Yes	No	Relationship
Diabetes	☐	☐	
Heart Problems	☐	☐	
High Blood Pressure	☐	☐	
Tuberculosis	☐	☐	
Sickle Cell Disease	☐	☐	
Cancer	☐	☐	

Other____

Females Only

Do you get regular PAP smears? Y N

Please list number of times pregnant _______

Please list the number of births _______

Have you ever had a mammogram? Y N

Do you perform regular self breast exams Y N

When was your last menstrual period? ________

To your knowledge, are you pregnant ? Y N

Comments: