OSF HEALTHCARE

PATIENT MEDICAL HISTORY
ADULT

C0390-0085

DATE _____

1.) SOCIAL HISTORY

Name _____ Birthdate ____/____/____
(Last) (First) (M.I.) (Month) (Day) (Year)

Occupation _____ Education (# of Years Completed) _____

Marital Status _____ Spouse's Name _____ Religion _____

Special cultural beliefs that might affect your healthcare _____

Do you have a Power of Attorney for Healthcare? ❑ Yes ❑ No Do you have a living will? ❑ Yes ❑ No

Use of home health or other community services? ❑ Yes ❑ No

Name of Health Care Providers _____

2.) PAST MEDICAL HISTORY

Have you ever had (if so, when): _____

- ❑ Alcoholism
- ❑ Aids / related complex
- ❑ Anemia
- ❑ Asthma
- ❑ Bone / joint problems
- ❑ Cancer; type: _____
- ❑ Coronary heart disease
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Emotional problems
- ❑ Epilepsy / seizures
- ❑ Gallbladder
- ❑ Gonorrhea
- ❑ Hemorrhoids
- ❑ Herpes
- ❑ High cholesterol / lipid levels
- ❑ High / Low blood pressure
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Liver disease / hepatitis
- ❑ Migraines
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Sexually transmitted disease
- ❑ Stomach disease
- ❑ Stroke / paralysis
- ❑ Thyroid disease
- ❑ Tuberculosis

Other: _____

3.) HOSPITALIZATIONS

Have you been hospitalized for any other problems? ❑ Yes ❑ No (If so, please list) _____

_____

Have you had: ❑ Appendectomy ❑ Tonsillectomy (age ____) ❑ Cholecystectomy (Gallbladder)

❑ Other surgeries: _____

4.) FAMILY HISTORY

Has any blood relative ever had: (Check all that apply)

- ❑ Alcoholism/Substance Abuse
- ❑ Alzheimer's disease
- ❑ Anemia
- ❑ Asthma
- ❑ Bleeding problem
- ❑ Cancer; type _____
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Memory loss
- ❑ Mental illness
- ❑ Thyroid disease
- ❑ Osteoporosis
- ❑ Senility
- ❑ Stroke
- ❑ Tuberculosis; when _____
- ❑ Other _____

5.) MEDICINES

Also include any over-the-counter medications such as vitamins, antihistamines, Tylenol, herbal remedies, etc.

_____ _____

_____ _____

_____ _____

_____ _____

6.) ALLERGIES

Please check items to which you are allergic:

❑ Drug allergies: (specify) _____

❑ Food/environmental allergies (specify) _____

❑ Iodine - Shellfish ❑ Bee stings / Insect bites ❑ X-ray / Arteriogram or dyes ❑ Adhesive tape ❑ Latex

❑ Other allergies: (specify) _____

_____

7.) IMMUNIZATIONS

Check those that you have had. (Please note the most recent year received.)

❑ Usual childhood immunizations _____ ❑ Flu _____ ❑ Pneumonia _____ ❑ Tetanus _____

❑ Chicken pox _____ ❑ Hepatitis _____ ❑ Others _____

8.) HABITS

Do you exercise regularly? ❑ Yes ❑ No How? _____ How long? _____ How often? _____
Do you drink caffeinated beverages? ❑ Yes ❑ No How much? _____ Daily / Weekly How long? _____
Do you drink alcoholic beverages? ❑ Yes ❑ No How much? _____ Daily / Weekly
Type _____ How long? _____
Do you now, or have you ever used: ❑ Cigarettes Packs/Day _____ X _____ years ❑ Pipe X _____ years
❑ Chewing tobacco X _____ years ❑ Cocaine X _____ years
❑ Marijuana X _____ years If discontinued, when? _____ ❑ Others: _____
Do you regularly use a seat belt? ❑ Yes ❑ No

9.) NUTRITION ASSESSMENT

Have you recently changed the kind and/or amount of food you eat? ❑ Yes * ❑ No
If yes, was it due to: an illness? Lack of money to buy food? Trying to lose or gain weight? Other? _____
Are you on a special diet? ❑ Yes * ❑ No
If yes, what type of diet? _____
Has your weight changed 10 pounds or more in the past 6 months? ❑ Yes * ❑ No
Amount gained _____ or lost _____
Do you have diabetes? ❑ Yes * ❑ No
Have you seen a dietician in the past year? ❑ Yes ❑ No *
Do you take an herbal, vitamin/mineral, nutritional drinks or supplements? ❑ Yes ❑ No
If yes, what? _____
Would you like more information about healthy eating? ❑ Yes * ❑ No

10.) GENERAL SCREEN / REVIEW OF SYSTEMS

** May indicate referral to dietician*

Please indicate any of the following problems which you might have right now.

❑ Blood in stools
❑ Breast masses/discharge
❑ Bruising
❑ Calf cramps, walking or at night
❑ Chest pain/discomfort
❑ Constipation
❑ Coughing spells/lots of phlegm
❑ Crying spells/depression
❑ Difficulty starting urinary stream
❑ Diarrhea
❑ Dizzy spells/blackouts
❑ Enlarged veins in legs
❑ Family/work problems
❑ Fever
❑ Frequent headaches
❑ Loose stools
❑ Loss of height
❑ Loss of urine
❑ Mouth/throat swelling
❑ Palpitations, unusual heartbeats
❑ Sudden loss of vision
❑ Swelling hands, feet, ankles
❑ Trouble breathing-exercise or lying down
❑ Trouble with ears/hearing
❑ Trouble with eyes
❑ Trouble with nose-bleeding, congestion
❑ Trouble with stomach digestion
❑ Trouble with urination
❑ Unusual fatigue
❑ Vomiting
❑ Weight change
❑ Other: _____

Last Dental Exam: _____ Last Vision Exam: _____ Last Rectal Exam / Colonoscopy: _____

11.) PAIN ASSESSMENT

(Please indicate body site, intensity of pain, things that make your pain better or worse)

Body Site: _____ No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Worst Pain Imaginable
What makes this pain better? (ie. rest, heat, medicine): _____
What makes this pain worse? (ie. walking, standing, lifting): _____

12.) SEXUAL HISTORY (Men & Women)

Are you sexually active: ❑ Yes ❑ No Lifetime number of partners: _____
Current contraception method or protection against STD: _____ Any sexual dysfunction or pain? _____
Any sexual concerns or questions? _____

13.) MEN ONLY

Last rectal exam: _____ Last PSA: _____
Practicing monthly testicular exam: ❑ Yes ❑ No ❑ Need information Difficulty urinating: _____

14.) WOMEN ONLY

Last menstrual period: _____
Age at onset: _____ ❑ Regular ❑ Irregular
Flow: ❑ Heavy ❑ Moderate ❑ Light Length of
Pain/cramps with menses: ❑ Yes ❑ No periods: _____
Days of flow (number): _____
Length of cycle: _____
Last Pap smear: _____
Last mammogram: _____
Monthly self breast exam: ❑ Yes ❑ No
Menopause: ❑ Yes ❑ No Age: ____
Symptoms of menopause: _____

Pain/bleeding after sex: ❑ Yes ❑ No
Pregnant: ❑ Yes ❑ No
Planning pregnancy: ❑ Yes ❑ No
Number of pregnancies: _____
Number of ectopic pregnancies: _____
Number of live births: _____
Number of miscarriages: _____ Number of abortions: _____
Contraception method: _____
Name of birth control pill if using: _____
Any concerns or questions? _____

❑ **I reviewed, agree and/or made changes as necessary to form:** Provider Signature: _____ Initial: _____ Date: _____