MEDICAL HISTORY FORM AND HEALTH RISK PROFILE ACCESSHEALTH DATE_____

MR. NO. _____

Name_____ Birthdate_____

Medication Allergies_____ Sex: Male___Female___

Please place a checkmark on blank beside and condition DIAGNOSED BY A DOCTOR OR OTHER PROVIDER, and indicate the date of onset. Leave all others BLANK.

CONDITION DATE

Metabolic/Hormonal disorders
___Cholesterol dis. _____
___Diabetes _____
___Gout _____
___Menopause _____
___Thyroid problems _____
___Other (list) _____

Ears, eyes, nose and throat
___Cataracts _____
___Glaucoma _____
___Deaf ___Blind _____
___Allergies _____
___Other (list) _____

Stomach and Digestive disorders
___Colitis _____
___Hemorrhoids _____
___Reflux/Esophagitis _____
___Gastritis/Ulcers _____
___Gallstones _____
___Pancreatitis _____
___Diverticulosis _____
___Other (list) _____

Skin disorders
___Acne _____
___Eczema _____
___Psoriasis _____
___Rosacea _____
___Other (list) _____

Heart and Circulation disorders
___Angina _____
___Blood clots _____
___High blood pressure_____
___Heart Attack _____
___Heart failure _____
___Heart Murmur _____
___Stroke _____
___Other (list) _____

CONDITION DATE

Kidney and bladder disorders
___Kidney stones _____
___Kidney failure _____
___Prostate problems _____
___Freq. Infections _____
___Other (list) _____

Bone and Joint disorders
___Amputations _____
___Arthritis _____
___Bone or joint infection_____
___Osteoporosis
___Other (list) _____

Blood or clotting disorders
___Anemia _____
___Bleeding problems _____
___Transfusion _____
___Other (list) _____

Cancers
___Cervix _____
___Colon _____
___Head and neck _____
___Leukemia _____
___Lung _____
___Lymphoma _____
___Prostate _____
___Uterus _____
___Other (list) _____

Infections
___AIDS/HIV _____
___Chlamydia _____
___Gonorrhea _____
___Herpes _____
___Hepatitis ___B___C _____
___Rheumatic fever _____
___Syphilis _____
___Tuberculosis _____
___Other (list) _____

CONDITION DATE

Lung disorders
___Asthma _____
___Bronchitis/COPD _____
___Emphysema _____
___Other (list) _____

Mental and Nerve disorders
___Anxiety _____
___Dementia _____
___Depression _____
___Epilepsy/seizure _____
___Meningitis _____
___Migraine _____
___Multiple sclerosis _____
___Parkinsons _____
___Severe head injury _____
___Other (list) _____

Other disorders
___Lupus _____
___Sarcoid _____
___Fibromyalgia _____
___Chronic fatigue _____
___Other not previously listed_____

Medications_____

Name Dose

SURGERIES AND MAJOR PROCEDURES – please check appropriate box and the DATE you had surgery or procedure.

Removal : ___Appendix_____ ___Tonsils_____ ___Breast_____ ___Spleen_____
___Kidney_____ ___Uterus (womb)_____ ___Gallbladder_____ ___Thyroid_____
___Stomach_____ ___Tubes tied_____ ___Vasectomy_____
___Back/joint surgery_____(specify joint)_____

___Cardiac Catheterization_____ ___Coronary stent_____ ___Coronary Bypass surgery_____

Other surgeries/Procedures_____

PLEASE COMPLETE OTHER SIDE ➔

REVIEW OF SYSTEMS – check symptoms you have – leave BLANK if not applicable.

1___Unexplained weight loss	7___Loss of consciousness	13___Vomited blood	19___Breast lumps
2___Persistent headaches	8___Lumps in testicles	14___Lose urine or slow urine	20___Recurrent belly pain
3___Persistent cough	9___Recurrent fever	15___Problems w/ erection	21___Persistent diarrhea
4___Sores that won't heal	10___Recurrent sore throat	16___Paralysis of any part	22___Abn. Vaginal bleed
5___Blood in bowels	11___Cough blood	17___Night sweats	23___Loss of vision
6___Blood in urine	12___Moles that changed	18___Persistent chest pain	24___Suicidal thoughts

(Nl=normal; Abnl=abnormal)

WOMEN – Latest mammogram _____ __Normal __Abnl ; Last Papsmear_____ __Nl __Abnl

Age at Menopause_____#Pregnancies_____ Maternal Substance Use: _____

Abortions____Miscarriages____Living children____ Blood Exposure/Transfusion__Yes, Date:_____

FAMILY HISTORY – please indicate which illnesses and which family member is/was affected.

M=Mother F=Father S=Sibling GM=Grandmother GF= Grandfather P=Paternal MGM=Maternal Grandmother

___Alcoholism_____	___Cancer ___DES	___High blood pressure	___Thyroid disease_____
___Asthma_____	___Breast_____	___Kidney disease	___Suicide_____
___Bleeding disorders____	___Cervix_____	___Mental illness	Does your spouse/part-
___Diabetes_____	___Colon_____	___Migraine	ner or close family mem-
___Epilepsy_____	___Lung_____	___Osteoporosis	ber have:___HIV___TB
___Heart disease_____	___Pancreas_____	___Stroke	___Hepatitis ___B___C

IMMUNIZATION HISTORY-check which vaccines you have had as an adult, with dates.

___Tetanus_____ ___Pneumonia (Pneumovax)_____ ___Varicella_____

___Hepatitis A_____ ___Hepatitis B_____ ___MMR_____

Have you ever had a positive TB skin test _____Yes _____No When ?_____ Date of latest neg._____

SOCIAL HISTORY AND RISK ASSESSMENT

Education level attained: _____Grade _____High School Grad. _____College _____Degrees Type_____

Usual Occupation _____ If unemployed, date last worked_____

Marital Status: _____Married _____Divorced _____Single _____Separated _____Widowed

HABITS - checkmark if yes, leave BLANK if none or no.

_____ Smoking: amt:_____ How Long?_____ Year quit_____ _____Chew/Dip

_____Alcohol (Beer, Wine, Liquor) _____Occasionally _____Daily: Number drinks/beers per day_____

Have you ever felt the need to CUT DOWN on drinking? _____Yes _____No

Have you ever felt ANNOYED when someone criticized your drinking? _____Yes _____No

Have you ever felt GUILTY about drinking? _____Yes _____No

Do you ever need an EYE OPENER drink in the morning? _____Yes _____No

___Regular exercise Type_____ How often ?_____

___Drug use: ___never _____Cocaine _____IV Drugs _____Presently _____Previously Year quit_____

_____Brush teeth daily _____wear sunscreen/protection _____Wear seat-belts _____Secure guns/ammo

___Sexually active _____one partner _____more than one partner _____partner of same sex

____Partner practiced needle drug use _____Partner had sex with someone of same sex

In the past year, were you hit, slapped, kicked, pushed or otherwise physically hurt by someone?___Yes ___No

In the past year, has anyone forced you to have sexual activities? ___Yes___No

The answers provided above is the history that I want my provider to know about. Any blank responses are purposefully left blank.

Signature, Patient_____Date_____

Signature, Physician/provider_____Date_____

RISK MANAGEMENT PLAN – Review of history indicates need for intervention in (enter date and initial):

	Date	Initial	Date	Initial	Date	Initial
1.Cardiovascular risk						
2.Immunization update						
3.Substance abuse						
4.STD Prevention						
5.Safety/Violence						
6.Exercise/Nutrition						
7.Preventive Health Issues						
8.Medical History Update						

PLEASE COMPLETE OTHER SIDE ➔