Clear Form

Tewksbury Family Health

A CIRCLE HEALTH MEMBER

Complete connected care℠

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

- ☐ Congenital Heart Disease: *please specify*:_____
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Hypertension (High Blood Pressure)
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Cancer (Malignancy) *please specify*:_____
- ☐ Stroke
- ☐ Coagulation (Bleeding/Clotting)
- ☐ Depression/Suicide Attempt
- ☐ Alcoholism
- ☐ Hepatitis A, B, or C (*specifiy*)_____

Date of Last Colonoscopy: _____
Date of last Tetanus Shot: _____
Date of last HIV Test: _____
Date of Blood Transfusion: _____
Other:_____

SURGICAL HISTORY: *Please list all prior surgeries and dates.*

Surgery	Date

IMMUNIZATIONS: *Please list your most recent immunizations, not including those administered at Lowell General Hospital. Please include your best estimate of the month and year of each immunization.*

Hepatitis A: _____ Measles: _____ Mumps: _____ Rubella: _____ MMR: _____
Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Other: _____

WOMEN'S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: *(For Women Only)*

# of Pregnancies: _____ # of Deliveries: _____ # of Abortions: _____ # of Miscarriages: ____ Age at 1st menses: ___
Frequency of menses: _____ Length of menses: _____ Date of last menses: _____ Date of last mammogram: _____

Do you have any concerns about your period or menopause? □ Yes □ No Please explain: _____
Have you ever had an abnormal pap smear? □ Yes □ No If circled yes, when was it? _____

FAMILY HISTORY: *Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother		☐	☐	☐	☐	☐	☐		☐	☐	
Father		☐	☐	☐	☐	☐	☐		☐	☐	
Siblings		☐	☐	☐	☐	☐	☐		☐	☐	
Maternal Grandmother		☐	☐	☐	☐	☐	☐		☐	☐	
Maternal Grandfather		☐	☐	☐	☐	☐	☐		☐	☐	
Paternal Grandmother		☐	☐	☐	☐	☐	☐		☐	☐	
Paternal Grandfather		☐	☐	☐	☐	☐	☐		☐	☐	
Other Family Members Information: *(please write in)*											

SOCIAL HISTORY:

Exercise:
Do you exercise regularly? □ Yes □ No

Tobacco Use:
□ Current □ Never □ Former: quit on: _____
*If current # of packs/day ___ # of years ____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

SAFETY
Do you wear a seatbelt regularly? □ Yes □ No
Do you wear a bike helmet regularly?
□ Yes □ No
Do you feel safe at home? □ Yes □ No
Do you feel safe in your current relationship?
□ Yes □ No

Drug Use:
Do you use any recreational drugs?
□ Yes □ No
If yes please list _____
If you have used in the past, how long have you been drug free? _____
Have you ever used needles for IV drug use? □ Yes □ No

Have you ever been physically or sexually abused? □ Yes □ No
Do you have a gun in your home?
□ Yes □ No
Are you a member of a gang? □ Yes □ No
Other concerns: _____
_____

Alcohol Use
Do you drink alcohol? □ Yes □ No
If yes, # of drinks per week: _____
What type of alcohol: _____
Is alcohol a concern for you or others who surround themselves around you?
□ Yes □ No

SOCIOECONOMICS
Occupation:_____
Degree of education completed:_____
Marital Status: _____
Spouse/Partner's Name: _____
Who lives at home with you? _____

SEXUALITY
Are you sexually active? □ Yes □ No
Current sex partner(s) are: □ male □ female
If sexually active do you practice safe sex?
□ Yes □ No
Other Concerns: _____
_____

Birth Control Method: _____
Have you ever had a sexually transmitted disease? □ Yes □ No
If yes, please include: _____
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Other Services
Have you had a recent eye exam? □ Yes □ No
Have you had a recent dental exam?
□ Yes □ No
Do you see any other specialists? _____
_____
_____

EMOTIONS

In the past year, have you had 2 or more weeks during which you felt sad or depressed; or you lost all interest or pleasure in things that you usually cared about or enjoyed? □ Yes □ No
Have you had 2 or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes? □ Yes □ No
Have you felt depressed or sad much of the time in the past year? □ Yes □ No
Do you ever feel like hurting yourself of others? □ Yes □ No

REVIEW OF SYSTEMS: *Please indicate with a check* (√) *any current problems you have below.*

Constitutional
- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/weakness
- ☐ Excessive thirst or urination
- ☐ Other: _____

_____

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Heart murmur or heart problems
- ☐ Palpitations
- ☐ Other: _____

_____

Chest
- ☐ Breast lump/discharge
- ☐ Other: _____

_____

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ringing in ears
- ☐ Hay fever/allergies
- ☐ Problems with teeth/gums
- ☐ Difficulty swallowing
- ☐ Difficulty with speech
- ☐ Other: _____

_____

Endocrine
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Abnormal hormone levels
- ☐ Abnormal blood glucose levels
- ☐ Other: _____

_____

Eyes
- ☐ Changes in vision
- ☐ Farsighted
- ☐ Nearsighted
- ☐ Other: _____

_____

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea
- ☐ Other: _____

_____

Genitourinary
- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Sexual function problems
- ☐ Discharge from penis
- ☐ Other: _____

_____

Gynecological
- ☐ Abnormal vaginal bleeding
- ☐ Problems with conceiving
- ☐ Problems with contraception
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Painful intercourse
- ☐ Other: _____

_____

Lymphatic/Blood
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding
- ☐ Anemia
- ☐ Other: _____

_____

Musculo-skeletal
- ☐ Muscle/joint pain
- ☐ Arthritis
- ☐ Other: _____

_____

Neurological
- ☐ Headaches
- ☐ Dizziness/light-headedness
- ☐ Numbness
- ☐ Memory loss
- ☐ Loss of coordination
- ☐ Epilepsy or convulsive seizures
- ☐ Other: _____

_____

Psychiatric
- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Depression
- ☐ Suicidal ideations
- ☐ Other: _____

_____

Respiratory
- ☐ Cough/wheeze
- ☐ Difficulty breathing
- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea
- ☐ Other: _____

_____

Skin
- ☐ Rash or mole change(s)
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other: _____

_____