Greater Elgin Family Care Center

INITIAL MEDICAL HISTORY

NAME: _____**AGE:** _____**DOB:** _____**TODAY'S DATE:**_____
(month/day/year)

PERSON COMPLETING FORM (IF OTHER THAN ABOVE) _____**RELATIOSHIP**_____

MEDICATIONS NOW TAKING	DOSE	FREQUENCY	REASON FOR MEDICINE (IF KNOWN)*

***IF MORE SPACE IS NEEDED, USE BACK OF FORM**

ALLERGIES: _____
_____

PATIENTS PERSONAL PAST MEDICAL & SURGICAL HISTORY – CHECK IF APPROPIATE

	YEAR		YEAR		YEAR
☐ Alcoholism	_____	☐ German Measles	_____	☐ Pneumonia	_____
☐ Angina	_____	☐ Glaucoma	_____	☐ Polio	_____
☐ Arthritis	_____	☐ Gout	_____	☐ Psychiatric Problems	_____
☐ Asthma	_____	☐ Hearth Problems	_____	☐ Rheumatic Fever	_____
☐ Blood Disease	_____	☐ Hemorrhoid	_____	☐ Hearth Disease	_____
☐ Breast Cancer	_____	☐ Hepatitis	_____	☐ Rheumatoid Arthritis	_____
☐ Fibrocystic Breast Disease	_____	☐ Hernias	_____	☐ Skin Disease/Cancer	_____
☐ Bronchitis	_____	☐ High Blood Pressure	_____	☐ Sinusitis	_____
☐ Cancer/Tumor	_____	☐ Liver Disease/Cirrhosis	_____	☐ Thyroid Disease	_____
☐ Depression	_____	☐ Lung Problems	_____	☐ Tuberculosis	_____
☐ Diabetes	_____	☐ Kidney Problems/Stones	_____	☐ Ulcers	_____
☐ Emphysema	_____	☐ Major Trauma	_____	☐ Urinary Tract Infections	_____
☐ Epilepsy	_____	☐ Migraines	_____	☐ Venereal Disease	_____
☐ Gallstones	_____	☐ Pancreatitis	_____	☐ Other:	_____
					_____

HOSPITALIZATION (Besides pregnancies) Medical or Surgical

HOSPITALIZATION	YEAR	OPERATION OR ILLNESS	HOSPITAL	DOCTOR	CITY AND STATE
1st Hospitalization					
2nd Hospitalization					
3rd Hospitalization					

TESTS & IMMUNIZATIONS

	YEAR		YEAR		YEAR
☐ Chet X-Ray	_____	☐ Other X-Rays	_____	☐ Flu Vaccine	_____
☐ Electrocardiogram	_____		_____	☐ Tetanus	_____
☐ Mammogram	_____		_____	☐ TB Test	_____
☐ Cholesterol	_____			☐ Pneumovaccine	_____

OBSTETRICAL & GYNE PAST HISTORY (IF APPLICABLE)

AGE ONSET OF PERIODS_____
AGE OF STOPPING PERIODS_____
FREQUENCY OF PERIODS _____
DURATION OF PERIODS_____
MENSTRUAL PAIN_____
LMP _____
DATE OF LAST PAP SMEAR _____
NAME OF OB-GYNE DOCTOR, IF ANY
_____

No. OF TIMES PREGNANT_____
No. OF MISCARRIAGES_____
No. OF LIVING CHILDREN_____
ANY D&C's IN PAST? _____NO._____WHEN_____
USE OF CONTRACEPTIVE PILL PRESENTLY_____
EVER IN THE PAST? ☐ YES ☐ NO
FORM OF CONTRACEPTIVE PRESENTLY USED (IF ANY)
_____

For Staff use only:
Patient Name: _____DOB: _____ MRN: _____
Rev. 2.2016

Greater Elgin Family Care Center

FAMILY HISTORY: Indicate the state of health and medical history for your family member by placing an X in the appropriate box.

	Alive	Died	Age	Cause of Death	Allergies	Asthma	Alcoholism	Diabetes	Cancer or Tumor	Epilepsy	Glaucoma	Gout	High Blood Pressure	Kidney or Bladder Trouble	Stomach Duodenal Ulcer	Nervous Breakdown	Rheumatism or Arthrits	Heart Trouble	Migraines	Obesity
FATHER																				
MOTHER																				
BROTHERS																				
SISTERS																				
SPOUSE																				
CHILDREN																				
GRANDPARENTS																				

SOCIAL HISTORY: CHECK APPROPIATE BOX

YOUR OCCUPATION _____

YES **NO**

☐ ☐ Do you regularly smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Others _____ For how many years? _____ How many packs? _____

☐ ☐ Do you use snuff or chewing tobacco?

☐ ☐ Do you usually drink over 4 cups of coffee per day?

☐ ☐ Do you drink alcohol? ☐ 1 oz./day ☐ 2 oz./day ☐ 4 oz./day ☐ over 6 oz./day

Beer: ☐ 1 bottle/day ☐ 2 bottles/day ☐ over 4 bottles/day

☐ ☐ Do you or have you used marijuana, cocaine or other similar drugs?

Which drug_____ How often _____ How much _____

☐ ☐ Do you regularly use "over-the-counter drugs" i.e., aspirin, cold preparations, nasal sprays? Which ones? _____

☐ ☐ Do you take tranquilizers, i.e. Valium, Lithium, etc.

☐ ☐ Do you take sleeping pills?

☐ ☐ Are you in an "unsafe" relationship (i.e. is there any physical or metal abuse at home, work or otherwise?)

REVIEW: Check any of the listed symptoms which <u>currently</u> apply to you. Space is provided for listing additional ones.

CONSTITUTIONAL:

☐ Weakness
☐ Fatigue
☐ Weight Loss (When)?_____
☐ Weight Gain (When)?_____
☐ Fever
☐ Chills
☐ Night Sweats
☐ Change in Appetite
☐ Insomnia
☐ Other: _____

EYES:

☐ Double Vision
☐ Glasses
☐ Date Changed: _____
☐ Loss of Vision _____
☐ Spots
☐ Pain
☐ Tears
☐ Infections
☐ Other: _____

NOSE, THROAT, SINUSES:

☐ Nosebleeds
☐ Sores
☐ Bleeding Gums
☐ Sore Tongue
☐ Sore Throat
☐ Hoarseness
☐ Postnasal Drip
☐ Sinusitis
☐ Other: _____

For Staff use only:
Patient Name: _____DOB: _____ MRN: _____
Rev. 2.2016

Greater Elgin Family Care Center

EAR:
- ☐ Pain
- ☐ Discharge
- ☐ Ringing
- ☐ Deafness
- ☐ Other: _____

SKIN, HAIR:
- ☐ Color Changes
- ☐ Itching
- ☐ Moles
- ☐ Infections
- ☐ Rash
- ☐ Hair Change
- ☐ Other: _____

RESPIRATORY:
- ☐ Cough
- ☐ Sputum
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Pleurisy
- ☐ Asthma
- ☐ Spitting up Blood
- ☐ Seasonal Allergy
- ☐ Bronchitis
- ☐ Other: _____

BREAST:
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Other: _____

CORDIOVASCULAR:
- ☐ Chest Pain
- ☐ Shortness of Breath on Exertion
- ☐ on lying down
- ☐ at night
- ☐ Wheezing
- ☐ How many pillows for sleep?
- ☐ Swelling of Feet
- ☐ Palpitation / Irregular Heart Beat
- ☐ Faintness
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ History of Rheumatic Fever
- ☐ Varicose Veins
- ☐ Calves Hurt When Walking
- ☐ History of Scarlet Fever
- ☐ Other: _____

URINARY TRACT:
- ☐ Frequency
- ☐ Pain
- ☐ Urgency
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Discharge
- ☐ Venereal Disease
- ☐ Other: _____

GASTROINTESTINAL:
- ☐ Appetite Change
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty Swallowing
- ☐ Foods Causing Indigestion or Gas
- ☐ Frequent Indigestion
- ☐ Excessive Gas
- ☐ Vomiting Blood
- ☐ Abdominal Pain
- ☐ Jaundice
- ☐ Use of Milk or Antacid
- ☐ Diarrhea
- ☐ Constipation
- ☐ Recent Change in Bowel Habits
- ☐ Black or Light Stool
- ☐ Use of Laxatives
- ☐ Number of Meals Eaten Per Day _____
- ☐ Other _____

MUSCULOSKELETAL:
- ☐ Joint Pain or Swelling
- ☐ Bone Pain or Swelling
- ☐ Muscle Pain or Swelling
- ☐ Deformity
- ☐ Muscle Weakness
- ☐ Morning Stiffness
- ☐ Other: _____

ENDOCRINE:
- ☐ Goiter
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Palpitation
- ☐ Change in Voice
- ☐ Too-frequent Urination
- ☐ Excessive Water Drinking
- ☐ Over-Eating
- ☐ Muscle Spasms
- ☐ Abnormal Hair Growth
- ☐ Infertility
- ☐ Other: _____

NEUROLOGIC
- ☐ Convulsions
- ☐ Faintness
- ☐ Involuntary Urinations
- ☐ Stroke
- ☐ Weakness
- ☐ Speech Difficulty
- ☐ Dizziness
- ☐ Tremor
- ☐ Trouble with Gait
- ☐ Changes in Sensations
- ☐ Transient Blind Spells
- ☐ Loss of Coordination
- ☐ Numbness
- ☐ Tingling
- ☐ Headache
- ☐ Other: _____

FEMALE GENITAL SYSTEM:
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Abnormal Bleeding
- ☐ Bleeding After Menopause
- ☐ Menopausal Symptoms
- ☐ Bleeding After Intercourse

MALE GENITAL SYSTEM:
- ☐ Discharge
- ☐ Sore on Penis
- ☐ Pain in Testicle
- ☐ Prostatic Problems

OTHER:
- ☐ Lump in Throat
- ☐ Difficulty in Getting a Deep Breath
- ☐ Nervousness
- ☐ Numbness Around Mouth
- ☐ Little Pains in the Chest
- ☐ Loss of Memory
- ☐ Crying Spells
- ☐ Nightmares
- ☐ Depressions
- ☐ Cannot Sleep
- ☐ Early A. M. Awakening
- ☐ Unusual Fears
- ☐ Unusual Thoughts of Perceptions
- ☐ Hallucinations
- ☐ Problems Due to Impulse Behavior
- ☐ Is there a marriage or Sex Problem?

Do you want to discuss it with your doctor? ☐ Yes ☐ No

TRAUMA:
- ☐ Major Trauma
- ☐ Head Trauma
- ☐ Broken Bones
- ☐ Lacerations
- ☐ Other: _____

ADVANCE DIRECTIVES/ LIVING WILL:

Would you like information?

☐ Yes ☐ No

Reviewed by doctor ☐ Yes ☐ No

Date: _____

For Staff use only:

Patient Name: _____DOB: _____ MRN: _____

Rev. 2.2016