Merrimack Valley Internal Medicine Associates

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

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

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

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

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: _____
_____

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: _____

_____