**WELLESLEY MEDICAL PATIENT HEALTH HISTORY**

|  |  |  |  |  |  |  |  |  |
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| IDENTIFYING DATA | | | | | | MEDICAL HISTORY | | YEAR |
| Patient Name: | | | | | AGE: |  | |  |
| Date of Birth: | | | | |  | |  |
| Social Security Number: | | | | | |  | |  |
| **🞎** MALE  **🞎** FEMALE | Occupation: | | | | |  | |  |
| Marital Status: | Prior M.D. : | | | | |  | |  |
| Medications (prescribed & non-prescribed, including supplements) | | | | | |  | |  |
| DRUG NAME | | | DOSE | TAKEN HOW OFTEN | |  | |  |
|  | | |  |  | | SURGICAL HISTORY | | YEAR |
|  | | |  |  | |  | |  |
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|  | | |  |  | | ALLERGIES | REACTIONS | |
|  | | |  |  | |  |  | |
| CURRENT IMMUNIZATION STATUS | | | | | |  |  | |
| TYPE: | | APPROXIMATE DATE: | | | |  |  | |
| TETANUS: | |  | | | |  |  | |
| PNEUMONIA VACCINE | |  | | | |  |  | |
| OTHER: | |  | | | | HABITS/SOCIAL | | |
|  | |  | | | | EXERCISE? | | |
|  | |  | | | | ALCOHOL USE?  HOW MUCH/HOW OFTEN? | | |
|  | |  | | | | TABACCO USE? PACKS PER PACK?  NUMBER YEARS SMOKED? YEAR QUIT SMOKING? | | |
|  | |  | | | |
|  | |  | | | | SEXUAL ORIENTATION:  **🞎**HETEROSEXUAL**🞎**HOMOSEXUAL**🞎**BISEXUAL | | |
|  | |  | | | |
| ADVANCE DIRECTIVES | | | | | | HIV RISK FACTORS? | | |
| DO YOU HAVE AN ADVANCE DIRECTIVE? **🞎** YES**🞎**NO | | | | | | DO YOU WEAR SEATBELTS? **🞎** YES **🞎** NO | | |

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| FAMILY HISTORY | | | | | | | | | | | | |
|  | **Age**  **(IF)**  **(LIVING)** | **Age**  **( AT )**  **(DEATH)** | **ASTHMA** | **HEART**  **DISEASE** | **CANCER**  **(TYPE)** | **DIABETES** | **EPILEPSY** | **HIGH**  **BLOOD**  **PRESSURE** | **HIGH**  **CHOLESTEROL** | **DEPRESSION** | **THYROID**  **(TYPE)** | **STROKE** |
| MOTHER |  |  |  |  |  |  |  |  |  |  |  |  |
| FATHER |  |  |  |  |  |  |  |  |  |  |  |  |
| SIBLINGS |  |  |  |  |  |  |  |  |  |  |  |  |
| CHILDREN |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL  Grandmother |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL  Grandfather |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL  Grandmother |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL  Grandfather |  |  |  |  |  |  |  |  |  |  |  |  |
| ***PLEASE LIST OTHER:*** | | | | | | | | | | | | |

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| WHAT SERIOUS MEDICAL CONDITION OR DISEASE DO YOU HAVE? | | | | | | | |
| GENERAL | *Do you have now?* | | URINARY TRACT | | *Do you have now?* | SCREENING TEST | *Month/*  *Year* |
| WEAKNESS |  | | FREQUENCY | |  | COLONOSCOPY |  |
| DIZZINESS |  | | URGENCY | |  | MAMMOGRAM |  |
| FAINTING |  | | INCONTINENCE | |  | VISION TEST |  |
| UNINTENDED WEIGHT LOSS |  | | BLOOD IN URINE | |  | LAST PHYSICAL EXAM |  |
| HEADACHES |  | | JOINTS | |  | BONE DENSITY |  |
| SKIN |  | | JOINT PAIN | |  |  |  |
| SKIN RASH |  | | MUSCLE PAIN | |  |  |  |
| ITCHING |  | | TENDONITIS | |  |  |  |
| HEAD & NECK |  | | NEUROLOGY | |  |  |  |
| HEARING LOSS |  | | SEIZURES | |  |  |  |
| VISION LOSS |  | | TREMOR | |  |  |  |
| RINGING IN YOUR EARS |  | | TROUBLE SPEAKING | |  |  |  |
| NECK PAIN |  | | FREQUENT FALLS | |  |  |  |
| THYROID PROBLEMS |  | | TROUBLE WALKING | |  |  |  |
| HEART |  | | POOR COORDINATION | |  |  |  |
| CHEST PAIN |  | | WOMEN ONLY | |  |  |  |
| SHORTNESS OF BREATH |  | | DATE OF LAST PAP SMEAR | |  |  |  |
| HEART PALPITATIONS |  | | DATE OF LAST PERIOD | |  |  |  |
| SWELLING |  | | METHOD OF BIRTH CONTROL | |  |  |  |
| INABILITY TO EXERCISE |  | | PREVIOUS ABNORMAL PAP | |  |  |  |
| LUNGS |  | | # OF PREGNANCIES | |  |  |  |
| COUGH |  | | # OF MISCARRIAGES | |  |  |  |
| WHEEZING/ASTHMA |  | | # OF CHILDBIRTHS | |  |  |  |
| COUGHING UP BLOOD |  | | # OF ABORTIONS | |  |  |  |
| NIGHT SWEATS |  | | OTHER PREGNANCY INFORMATION NOT LISTED ABOVE: | | | | |
| STOMACH |  | |
| NAUSEA |  | | MOOD | | | | |
| VOMITING |  | | FELT DOWN OR DEPRESSED IN THE PAST FEW WEEKS?  **🞎**YES **🞎**NO | | | | |
| DIARRHEA |  | |
| CONSTIPATION |  | | FEEL LITTLE INTEREST OR PLEASURE IN DOING THINGS IN THE PAST FEW WEEKS?  **🞎**YES **🞎** NO | | | | |
| STOMACH PAIN |  | |
| CHANGE IN BOWEL HABITS |  | |  | | | | |
| BLOOD IN STOOLS |  | |
| **COMPLETED BY (other than patient):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **RELATIONSHIP TO PATIENT:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **EMERGENCY CONTACT INFORMATION** | | | | | | | |
| NAME | | RELATIONSHIP | | PHONE # (please specify if home, mobile, or work) | | | |
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