**WELLESLEY MEDICAL PATIENT HEALTH HISTORY**

|  |  |  |
| --- | --- | --- |
|  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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  | 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 |

|  |
| --- |
|  |

|  |
| --- |
| 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 |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNALGrandmother |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL Grandfather |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNALGrandmother |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL Grandfather |  |  |  |  |  |  |  |  |  |  |  |  |
| ***PLEASE LIST OTHER:*** |

|  |
| --- |
| 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) |
|  |  |  |
|  |  |  |