MyCare Health Center

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www.mycarehealthcenter.org

Medical Center Health History

Name:	Date of Birth:	Today's Date:

Health History

What primary care physician do you see?

_____

Have you created Advanced Directives to appoint a patient advocate to make health care decisions for you if you become incapacitated? ..... Yes No

If not, would you like to know more about how to do so? ..... Yes No

Are you presently being treated for any condition? ..... Yes No

If yes, what: _____

Has your health changed in the past year? Better Worse Same

Describe: _____

Can you bathe and dress yourself? ..... Yes No

Do you need assistance to walk? ..... Yes No

Have you had any operations? ..... Yes No

If yes, what: _____ Year_____

Do you suffer from chronic pain (pain that you have all the time)? ..... Yes No

If yes, where: _____

Are you suffering from acute pain (pain that comes on suddenly? ..... Yes No

If yes, where? _____

When did it start? _____

Does anything relieve it? _____

Describe the severity of the pain on a scale of 0 to 10, with 10 being the worst possible pain. _____

Medications

List any prescription medications that you take.

Medication:	Dosage:	Freq.:	Date started:

List any over-the-counter medications you take regularly, including vitamins and herbals:

Medication:	Dosage:	Freq.:	Date started:

Pharmacy (Name & Location)_____

Are you allergic to any medications? ..... Yes No

If yes, which ones? _____

What is the reaction? _____

When was your last flu shot? _____

When was your last tetanus shot? _____

Have you had a pneumonia vaccination?...Yes No Year:_____

Have you had the Hepatitis B series? ..... Yes No

Habits

How much coffee and caffeinated beverages do you drink daily? _____

Do you now smoke (circle): cigarettes pipe cigars

If yes, number of packs per day: _____

Former smoker.....Yes No How many Packs per day:_____ Years _____

If you do smoke, are you interested in quitting? ..... Yes No

How long have you smoked? _____

Have you ever used any of the following substances for recreational purposes?

Alcohol...Yes No How often:_____ How much:_____ Former Heavy use Yes No

Cocaine ..... Yes No

Speed ..... Yes No

Marijuana ..... Yes No

Heroin ..... Yes No

PCP/LSD ..... Yes No

Glue/paint ..... Yes No

Any drugs with needles ..... Yes No

Any marked "Yes" When were they last used (year):_____

Nutrition

Are you allergic to any food? ..... Yes No

Please describe: _____

Do you have chewing, swallowing, or mouth problems that make it hard to eat? ..... Yes No

Have you had nausea, vomiting, or diarrhea for the last five days? ..... Yes No

Have you unintentionally lost or gained 10 pounds or more in the last six months? ..... Yes No

Are you able to afford adequate food? ..... Yes No

Are you able to shop for yourself? ..... Yes No

Are you able to cook for yourself? ..... Yes No

Are you able to feed yourself? ..... Yes No

Do you take nutritional supplements? ..... Yes No

Name:	Date of Birth:	Today's Date:

Have you ever been told you had any of the following conditions?

AIDS or HIV disease ..... Yes No
Arthritis, rheumatism, or bursitis (circle which apply) ..... Yes No
Cancer ..... Yes No

If yes, what type? _____ At what age? _____

Colitis, colon polyps, Crohn's Disease ..... Yes No
Depression or anxiety disorder ..... Yes No
Diabetes (high blood sugar) ..... Yes No
Fainting (passing out) ..... Yes No
Heart disease ..... Yes No
High blood pressure ..... Yes No
High cholesterol ..... Yes No
Kidney disease ..... Yes No
Liver disease ..... Yes No
Lung disease ..... Yes No

If yes, circle: asthma, emphysema, bronchitis, tuberculosis

Seizure disorder ..... Yes No
Sexually transmitted disease ..... Yes No

If yes, what type? _____ At what age? _____

Stroke ..... Yes No
Ulcer ..... Yes No
Other ..... Yes No
Details:

_____

_____

Personal and Social History

What is your marital status? S M D W
Whom do you live with? _____
Do you have supportive friends or family in the area? ..... Yes No
Your highest level of education: _____
Are you currently employed? ..... Yes No
If yes, what field: _____
Do you wear a seatbelt? ..... Yes No
If you ride a bike or motorcycle, do you wear a helmet? ..... Yes No
What is your preferred method of learning? (circle one)

Written Verbal Visual

Do you have any religious/cultural objections to any traditional medical procedures? ..... Yes No
Have you suffered from physical, sexual, or mental abuse? ..... Yes No
Have you ever felt threatened by anyone? ..... Yes No
Have you ever harmed yourself or thought about harming yourself? ..... Yes No
Have you ever had suicidal thoughts? ..... Yes No
Do you currently have suicidal thoughts? ..... Yes No

Family History

Does anyone in your family have any of the following:
If yes, list family member (father, mother, grandmother, etc.)

Concern			Family Member
Cancer	Yes	No	_____
			Type: _____
Liver disease	Yes	No	_____
Diabetes	Yes	No	_____
Lung disease	Yes	No	_____
Gynecological problems	Yes	No	_____
Neurological problems	Yes	No	_____
Heart disease	Yes	No	_____
Prostate problems	Yes	No	_____
High blood pressure	Yes	No	_____
Thyroid problems	Yes	No	_____
Kidney disease	Yes	No	_____
HIV/AIDS	Yes	No	_____

Females Only

Please complete:

_____ # of pregnancies _____ # of abortions
_____ # of miscarriages _____ # of live births
Any complications with pregnancy? ..... Yes No
If yes, describe: _____
Do you have painful periods? ..... Yes No
Irregular periods? ..... Yes No
Ever treated for female disorder? ..... Yes No
Last menstrual period (date): _____
Duration of period: _____
Last pap smear: _____ Results: _____
Last Mammogram: _____ Results: _____
Any previous abnormal pap smear? ..... Yes No
Contraception? ..... Yes No
Are you menopausal? ..... Yes No
If yes, what age? _____
What OB/GYN physician do you see? _____

How did you hear about us? _____

Email address: _____

Race/ethnicity: _____

Language spoken: _____

_____
Signature of person completing this form

_____
Date