Medical History Form

CHI St. Joseph Health

Name: _____ Date of Birth: _____

Medical History: (Please check if you have or had any of the following)

☐ Allergies	☐ Eye Problems	☐ Latex Allergies
☐ Anemia	☐ Fainting or Dizziness	☐ Liver Disease or Jaundice
☐ Asthma or Hay fever	☐ Frequent colds/Pneumonia	☐ Loss/Gain of weight
☐ Back problems	☐ Frequent Headaches	☐ Nervous or Mental Disorder
☐ Bladder Trouble	☐ Gallbladder	☐ Pain in Arms or Hands
☐ Bursitis or Shoulder pain	☐ Goiter or Thyroid Trouble	☐ Rheumatic Fever
☐ Cancer, Cysts, or Tumors	☐ Heart Trouble	☐ Rheumatism or Arthritis
☐ Change of Bowel habits	☐ Hepatitis or Cirrhosis	☐ Shortness of Breath
☐ Chest pain or pressure	☐ High or Low Blood Pressure	☐ Skin Trouble or Rashes
☐ Chronic cough or bronchitis	☐ Ill Effects from Medicine	☐ Swollen Joints
☐ Dermatitis	☐ Indigestion or Heartburn	☐ Varicose Veins
☐ Diabetes	☐ Irregular Heart Beat	☐ Wrist or Elbow Spasm
☐ Epilepsy	☐ Kidney or Bladder Disease	

Surgical History & Date/Age if known: **No surgeries: _____**

_____

_____

Hospitalizations: **No past hospitalizations: _____**

Date/Age: _____ Reason: _____

Date/Age: _____ Reason: _____

Family History: **History of:**

Father: Alive or Deceased Diabetes Hypertension Heart Disease Stroke Cancer Unknown

Mother: Alive or Deceased Diabetes Hypertension Heart Disease Stroke Cancer Unknown

Child: Alive or Deceased Diabetes Hypertension Heart Disease Stroke Cancer Unknown

Child: Alive or Deceased Diabetes Hypertension Heart Disease Stroke Cancer Unknown

Child: Alive or Deceased Diabetes Hypertension Heart Disease Stroke Cancer Unknown

Social History:

Tobacco Use: Yes No ____former or ____never Drug: Yes No Alcohol: Yes No

Sexually Active: Yes No Have you ever had a Sexually Transmitted Disease? Yes No

Medications currently taking (List) Name/Dosage/How often:

_____

_____

_____

Allergies: to medications, food, or latex (List): _____

FEMALES ONLY: Is it possible you may be pregnant? YES NO Date of last Menstrual Cycle: _____

Immunizations Up-To-Date? ____To my knowledge ____Not up-to-date ____Unknown (will discuss w/provider)

Injured at Work: YES NO Date/time of injury:_____

Today's Date: _____