MRE Family Care Clinic

MRE Family Care Clinic
404 E. Bloomington Street, Iowa City, IA 52245
Ph: 319.351.1483 Fax: 319.351.1027
Web: mrefamilycare.com

Medical History Form

Directions: Please answer the following questions to the best of your knowledge.

PATIENT INFORMATION			
Last Name	**First Name**	**Middle**	**Primary Language**
Reason for Initial Visit			

OTHER PHYSICIAN(S)		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

Are you currently being treated for any medical conditions? □ Yes □ No

If yes, please list:

PAST MEDICAL HISTORY/SURGICAL HISTORY (Please list age at time or date of surgery)		

MEDICATIONS (List more on separate page if necessary)

Current Medications	**For what condition?**	**Dosage**	**Frequency**	**Date started**	**Comments / Problems / Concerns**

Medication Allergies? □ Yes □ No
If yes, what medication(s)

Substance or Food Allergies? □ Yes □ No
If yes, what substance(s)

FAMILY HISTORY: Please check the box if your family has a history of:

□ Diabetes □ High Blood Pressure □ Heart Attack, Heart Disease □ Blood Clots or Stroke □ Tuberculosis
□ Cancer □ Alzheimer's □ Family History Unknown □ Mental Illness □ Epilepsy/Seizure

Any other major conditions?_____

_____

If you answered Yes to any of the above, please explain: _____

_____

Are you currently being treated for medical conditions? □ Yes □ No If yes, please list: _____

SOCIAL/SEXUAL RISK HISTORY	
□ Yes □ No	Do you smoke? If yes, how many cigarettes per day?
□ Yes □ No	Do you use alcohol? If yes, how often, how much?
□ Yes □ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
□ Yes □ No	Have you ever had or would you like help now with an alcohol or drug problem?
□ Yes □ No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
□ Yes □ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following:				
1. General				
Productive cough (3 weeks or more)	☐ Current ☐ Past		Unusual discharge (vaginal or from penis)	☐ Current ☐ Past
Dry, unproductive cough (3 wks or more)	☐ Current ☐ Past		Bloody or painful urination	☐ Current ☐ Past
Shortness of breath	☐ Current ☐ Past		Dark, bloody or painful bowel movements	☐ Current ☐ Past
Chest pain	☐ Current ☐ Past		Hepatitis A	☐ Current ☐ Past
Recurrent night sweats, chills, fevers	☐ Current ☐ Past		Hepatitis B	☐ Current ☐ Past
Swollen glands (neck, armpits or groin)	☐ Current ☐ Past		Hepatitis C	☐ Current ☐ Past
Persistent weight loss without dieting	☐ Current ☐ Past		Chronic Fatigue	☐ Current ☐ Past
Weight problem/eating disorder	☐ Current ☐ Past		Cancer	☐ Current ☐ Past
Tuberculosis: Ever tested? If Yes, date and result of last test If Positive, did you have a chest x-ray? If Positive, were you ever treated? Date(s) and type(s) of treatment	☐ Yes ☐ No _____ ☐ Yes ☐ No ☐ Yes ☐ No _____		**HIV:** Ever tested? If Yes, date and result of last test Would you like information regarding HIV/AIDS or testing sites?	☐ Yes ☐ No _____ ☐ Yes ☐ No
2. Skin			**5. Cardiac**	
Allergies/Rash/Itching	☐ Current ☐ Past		Palpitations/arrhythmia	☐ Current ☐ Past
Psoriasis / Eczema	☐ Current ☐ Past		Heart disease/murmur	☐ Current ☐ Past
			High blood pressure / Low blood pressure	☐ Current ☐ Past
3. Eyes			High cholesterol	☐ Current ☐ Past
Vision problems	☐ Current ☐ Past		Thrombophlebitis/blood clots	☐ Current ☐ Past
Eye infections	☐ Current ☐ Past			
4. Ears, Nose, Throat, Lungs			**6. Neurological**	
Hearing problems	☐ Current ☐ Past		Stroke	☐ Current ☐ Past
Teeth/gum problems or disease	☐ Current ☐ Past		Frequent Headaches or Migraines	☐ Current ☐ Past
Frequent nosebleeds	☐ Current ☐ Past		Seizures/Epilepsy	☐ Current ☐ Past
Recurrent sinusitis	☐ Current ☐ Past		Weakness/paralysis/unsteady walking	☐ Current ☐ Past
Frequent sore throats	☐ Current ☐ Past		Dizziness/confusion/wandering	☐ Current ☐ Past
Recurrent Pneumonia	☐ Current ☐ Past		Forgetfulness/memory lapse/memory loss	☐ Current ☐ Past
Asthma	☐ Current ☐ Past			
REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following:				
7. Gastrointestinal			**For Females:**	
Recurrent nausea/vomiting/diarrhea	☐ Current ☐ Past		Menstrual Difficulties	☐ Current ☐ Past
Stomach/bowel problems	☐ Current ☐ Past		Cycle: ☐ Regular ☐ Irregular	
Gall bladder disease	☐ Current ☐ Past		☐ Pre-Menopause ☐ Menopause	
Pancreatitis	☐ Current ☐ Past		Problems/infection of tubes/ovaries/uterus	☐ Current ☐ Past
Diabetes / hyperglycemia / hypoglycemia	☐ Current ☐ Past		Abnormal Pap Smear(s)	☐ Current ☐ Past
Encopresis (incontinent of feces)	☐ Current ☐ Past		Number of pregnancies	
			Number of births	
8. Genitourinary			Problems with pregnancies/births (explain)	
Bladder/kidney problems or infection	☐ Current ☐ Past			
Incontinence (unable to control bladder)	☐ Current ☐ Past		Breast disease / tumor / surgery (explain)	
Enuresis (bedwetting)	☐ Current ☐ Past			
Sexually transmitted diseases:			**Miscellaneous:**	
___Gonorrhea ___Syphilis ___Herpes			Anemia / blood disorder	☐ Current ☐ Past
___Chlamydia ___Trichomonas ___HPV or genital warts			Arthritis	☐ Current ☐ Past
			Sleep disturbance	☐ Current ☐ Past

Other conditions / problems not listed:

I certify that I have answered these questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date:_____