MRE Family Care Clinic
404. E. Bloomington St, Iowa City, IA 52245
P: 319.351.1483 F: 319-351-1027
mrefamilycare.com

Medical History Form

Please respond to the following questions in regards to the patient to the best of your ability:

First Name: _____ M.I. _____ Last Name:_____

Medical Conditions that you are currently treated for:

Current Medication List: You may provide on a separate page if you would like.

Medication Name	Dosage	Frequency	What diagnosis is this treating?

Allergies?

Allergen	Reaction	Onset?

Have you had any major injuries, procedures, surgeries, or hospitalizations?

Injury/Procedure/Illness	Date (year)	Injury/Procedure/Illness	Date (year)

If you are currently under the care of any other providers or specialist please fill out information below.

Provider Name	Clinic/Hospital	Specialty	What Diagnosis are they Treating?

Personal History:

History of Physical/Mental/Sexual Abuse?	Yes	No	Do you wish to discuss?	Yes	No
Are you sexually active?	Yes	No	Have you ever been tested for STI's	Yes	No
Do you wear glasses or contacts?	Yes	No	Would you like to be tested for STI's	Yes	No

Females: **Age of first period:** _____

Current reproductive Stage: Pre-Pubescent Cycling Pre-Menopause Menopause Post-Menopause

Circle all that apply to cycle: Regular Irregular Heavy Light 3-5days 6-8days 8+days

Have you ever had an abnormal pap-smear? Yes No Last Pap smear:_____

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Social History: Please mark to the following questions. If yes provide further details where indicated:

Current Nicotine User	Yes	No	Nicotine of Choice?		How much per day?	
Former Nicotine User	Yes	No	Nicotine of Choice?		When did you quit?	
Drink Alcohol	Yes	No	Beverage of Choice?		Drinks per week?	
Elicit Drug Use	Yes	No	Drug of Choice?		Frequency/Amount?	

Family History: Please indicate if any of the included relatives has/have had the following conditions and who:

Condition	Mother	Father	Sibling	Child	MGM	MGF	MA/MU	PGM	PGF	PA/PU
Diabetes (Type 1) (Type 2)										
Hypertension										
Heart Attack/Heart Dz										
Blood Clots										
Stroke										
Colon Cancer										
Breast Cancer										
Other Cancers?										
Alzheimers/Dementia										
Mental Illness										
Epilepsy/seizure										
Substance Abuse										
Autoimmune Disease										
COPD										
Thyroid disease										

Other significant histories:

_____

_____

Home/Work Life:

Occupation (or prior occupation): _____ Employer: _____
If you're not currently working are you: ___Retired ___Unemployed ___Leave of Absence ___Disabled ___Homemaker
Living Situation: ___Single Family Home ___Apartment/Condo ___Senior Living ___Assisted Living
Who do you live with: _____
How many children do you have: _____ Grandchildren?_____ Great Grandchildren?_____
Education: ___High-School/GED ___Associates ____Bachelors ___Masters ___Doctorate ___Trade school

Other:

Have you ever served in the military?	Yes	No	Branch:_____ When: _____-_____
Have you ever had a Blood transfusion?	Yes	No	When?
Exposure to toxic Chemicals?	Yes	No	When? Where? How Often?
Do you exercise Regularly?	Yes	No	What kind? How Often?
Do you follow a special Diet?	Yes	No	What Diet?

Any other information you would like to share with us? _____

_____