PATIENT MEDICAL HISTORY FORM
Please Print

Traverse Health Clinic

NAME: _____ DOB: _____ DATE: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. FOR ACCURACY, PLEASE BRING YOUR MEDICATION BOTTLES WITH YOU.

1		5		9	
2		6		10	
3		7		11	
4		8		12	

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	Headaches/Migraines	Hiatal Hernia	Osteopenia/Osteoporosis
Alcoholism	Crohn's Disease	High Blood Pressure	Parkinson's Disease
Allergies, Seasonal	COPD/Emphysema	High Cholesterol	Peripheral Vascular Disease
Anemia	Dementia	HIV	Peptic Ulcer
Anxiety	Depression	Hepatitis	Psoriasis
Arrhythmia (Irregular Heart Beat)	Diabetes: Type 1 or 2	Irritable Bowel Syndrome	Pulmonary Embolism (PE)
Arthritis	Diverticulitis	Kidney Disease	Rheumatoid Arthritis
Asthma	DVT (Blood Clot)	Kidney Stones	Seizure Disorder
Bipolar	GERD (Acid Reflux)	Lupus	Sleep Apnea
Bladder Problems/Incontinence	Glaucoma	Liver Disease	Stroke
Bleeding problems	Heart Disease	Macular Degeneration	Thyroid Disorder
Cancer: _____	Heart Attack (MI)	Neuropathy	Ulcerative Colitis

Other medical problems not listed above: _____

List ALL ALLERGIES/INTOLERANCES. Include the reaction (e.g., anaphylaxis, headache, rash, hives, swelling, hallucination, nausea, vomiting, shortness of breath, dizziness, diarrhea, fever, stomach upset, dehydration, depression, or suicidal).

Colonoscopy	Yes/No	Date (most recent):	Doctor/Facility:	Normal/Abnormal
Mammogram	Yes/No	Date (most recent):	Doctor/Facility:	Normal/Abnormal
Bone Density	Yes/No	Date (most recent):	Doctor/Facility:	Normal/Abnormal
PAP	Yes/No	Date (most recent):	Doctor/Facility:	Normal/Abnormal
Last Menstrual Period	Date:			Normal/Abnormal

CONTINUED ON OTHER SIDE

SURGICAL HISTORY: Please list all prior surgeries and approximate dates performed.

HOSPITAL ADMISSIONS: Please list all overnight hospital admissions for injury, illness, or mental health.

FAMILY MEDICAL HISTORY:

MOTHER: Living: Age: _____ Deceased: Age: _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes: Type 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	Other: _____

FATHER: Living: Age: _____ Deceased: Age: _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes: Type 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	Other: _____

SIBLINGS: Brothers: ____ **Sisters:** ____ **Medical Problems:** _____

CHILDREN: Sons: ____ **Daughters:** ____ **Medical Problems:** _____

SOCIAL/CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional

Occupation: _____ Living with: _____ Are you sexually active? Yes/No

Are there any vision or hearing problems that affect your communication? Yes/No Explain: _____

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of years: _____

Alcohol: ☐ Current ☐ Past ☐ Never How often: _____ Do you ever have six or more drinks on one occasion? Yes/No

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

How often do you get the social and emotional help you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments: _____

OTHER MEDICAL PROVIDERS: Please list all specialists you currently see on a regular basis (e.g., Heart Doctor, Mental Health Provider, Kidney Doctor, Eye Doctor, GI, etc.).

Patient Signature: _____ Date: _____