Westford Family Medicine

A CIRCLE HEALTH MEMBER

Complete connected care℠

MEDICAL HISTORY FORM

Patient Name: ______________________ DOB: ______/______/_______

Signature: _________________________ Date: _____/______/________

Present Health Concerns: ____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

<u>** If you are on 3 or more medications – please bring them with you to each appointment. **</u>

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

Congenital Heart Disease:
please specify:_________________
Myocardial Infarction (Heart Attack)
Hypertension (High Blood Pressure)
Diabetes
High Cholesterol

Cancer (Malignancy)
please specify:________________
Stroke
Coagulation (Bleeding/Clotting)
Depression/Suicide Attempt
Alcoholism

Hepatitis A, B, or C (*specifiy)*_______
Date of Last Colonoscopy: ____________
Date of last Tetanus Shot: ____________
Date of last HIV Test: ________________
Date of Blood Transfusion: ___________
Other:_____________________________

SURGICAL HISTORY: *Please list all prior surgeries and dates.*

Surgery	Date

IMMUNIZATIONS: *Please list your most recent immunizations, not including those administered at Lowell General Hospital. Please include your best estimate of the month and year of each immunization.*

Hepatitis A: _________ Measles: ___________ Mumps: ____________ Rubella: ____________ MMR: ______________
Hepatitis B: _________ Pneumovax: ________ Tdap: ______________ Varicella: ___________ Other: _____________

WOMEN'S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: *(For Women Only)*

# of Pregnancies: _____ # of Deliveries: _____ # of Abortions: _____ # of Miscarriages: ____ Age at 1st menses: ___
Frequency of menses: ______ Length of menses: _____ Date of last menses: _______ Date of last mammogram: _______

Do you have any concerns about your period or menopause? □ Yes □ No Please explain: ______________________________
Have you ever had an abnormal pap smear? □ Yes □ No If circled yes, when was it? ______________________________

FAMILY HISTORY: *Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

SOCIAL HISTORY:

Exercise:
Do you exercise regularly? □ Yes □ No
Tobacco Use:
□ Current □ Never □ Former: quit on: ______
*If current # of packs/day ___ # of years ____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Drug Use:
Do you use any recreational drugs?
□ Yes □ No
If yes please list ___________________
If you have used in the past, how long have you been drug free? ________
Have you ever used needles for IV drug use? □ Yes □ No

Alcohol Use
Do you drink alcohol? □ Yes □ No
If yes, # of drinks per week: __________
What type of alcohol: _______________
Is alcohol a concern for you or others who surround themselves around you?
□ Yes □ No

SAFETY

Do you wear a seatbelt regularly? □ Yes □ No
Do you wear a bike helmet regularly?
□ Yes □ No
Do you feel safe at home? □ Yes □ No
Do you feel safe in your current relationship?
□ Yes □ No

Have you ever been physically or sexually abused? □ Yes □ No
Do you have a gun in your home?
□ Yes □ No
Are you a member of a gang? □ Yes □ No
Other concerns: _____________________
____

SOCIOECONOMICS

Occupation:_________________________
Degree of education completed:_________
Marital Status: _______________________
Spouse/Partner's Name: _______________
Who lives at home with you? ___________

SEXUALITY

Are you sexually active? □ Yes □ No
Current sex partner(s) are: □ male □ female
If sexually active do you practice safe sex?
□ Yes □ No
Other Concerns: _____________________
____

Birth Control Method: _________________
Have you ever had a sexually transmitted disease? □ Yes □ No
If yes, please include: __________________
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Other Services

Have you had a recent eye exam? □ Yes □ No
Have you had a recent dental exam?
□ Yes □ No
Do you see any other specialists? __________
____
____

EMOTIONS

In the past year, have you had 2 or more weeks during which you felt sad or depressed; or you lost all interest or pleasure in things that you usually cared about or enjoyed? □ Yes □ No
Have you had 2 or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes? □ Yes □ No
Have you felt depressed or sad much of the time in the past year? □ Yes □ No
Do you ever feel like hurting yourself of others? □ Yes □ No

REVIEW OF SYSTEMS: *Please indicate with a check (√) any current problems you have below.*

Constitutional
Fevers/chills/sweats
Unexplained weight loss/gain
Fatigue/weakness
Excessive thirst or urination
Other: ______________________
____

Cardiovascular
Chest pain/discomfort
Leg pain with exercise
Heart murmur or heart problems
Palpitations
Other: ______________________
____

Chest
Breast lump/discharge
Other: ______________________
____

Ears/Nose/Throat/Mouth
Difficulty hearing/ringing in ears
Hay fever/allergies
Problems with teeth/gums
Difficulty swallowing
Difficulty with speech
Other: ______________________
____

Endocrine
Hypothyroid
Hyperthyroid
Abnormal hormone levels
Abnormal blood glucose levels
Other: ______________________
____

Eyes
Changes in vision
Farsighted
Nearsighted
Other: ______________________
____

Gastrointestinal
Abdominal pain
Blood in bowel movement
Nausea/vomiting/diarrhea
Other: ______________________
____

Genitourinary
Nighttime urination
Incontinence
Sexual function problems
Discharge from penis
Other: ______________________
____

Gynecological
Abnormal vaginal bleeding
Problems with conceiving
Problems with contraception
Vaginal discharge
Vaginal odor
Painful intercourse
Other: ______________________
____

Lymphatic/Blood
Unexplained lumps
Easy bruising/bleeding
Anemia
Other: ______________________
____

Musculo-skeletal
Muscle/joint pain
Arthritis
Other: ______________________
____

Neurological
Headaches
Dizziness/light-headedness
Numbness
Memory loss
Loss of coordination
Epilepsy or convulsive seizures
Other: ______________________
____

Psychiatric
Anxiety/stress
Problems with sleep
Depression
Suicidal ideations
Other: ______________________
____

Respiratory
Cough/wheeze
Difficulty breathing
Asthma
COPD
Sleep apnea
Other: ______________________
____

Skin
Rash or mole change(s)
Psoriasis
Eczema
Other: ______________________
____