

MARANA HEALTH CENTER

NAME: _____ **DOB:** _____ **DATE:** _____ **REASON for VISIT:** _____

The completion of this form enables MHC to provide you with a higher quality of medical care

MEDICAL HISTORY: Please check any and all conditions/illnesses which pertain to you

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Infertility | <input type="checkbox"/> Varicose Veins/phlebitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Abnormal Pap smear |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes I | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Breast Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes II | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> MI/Heart attack | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> DVT | <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> DES Exposure |
| <input type="checkbox"/> Biliary Cirrhosis | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Diabetes Gestational |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> RH Sensitized |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Uterine Anomaly |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Hypo thyroidism | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyper thyroidism | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> UTI recurrent | <input type="checkbox"/> Herpes Simplex Virus |

List any other illnesses if not listed above _____

PAST SURGERIES: Please check any and all surgical procedures that pertain to you

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Craniotomy | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> AV Fistula | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Mitral Valve Replacement |
| <input type="checkbox"/> Aortic Valve Replacement | <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Parathyroidectomy |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Hysterectomy Full / Partial |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> C- Section # _____ | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Tonsillectomy |

List any other surgeries if not listed above _____

FAMILY HISTORY: Check if it runs in family

HABITS: Please answer all questions

| | Father | Mother | Children | Siblings |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sickle Cell Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of cancer _____ | | | | |

Do you smoke? YES NO # Packs a day _____
 When did you start smoking? _____
 Do you live with smokers? YES NO
 Do you drink alcohol? YES NO
 BEER WINE LIQUOR Daily amount _____
 History or current drug use? YES NO
 Type of drug _____
 Do you exercise regularly? YES NO
 # of times per week _____ Type _____
 Do you wear your seatbelt in the car? YES NO
 How often? _____ (Percentage)
 How often are you in the sun?
 FREQUENTLY OCCASIONALLY RARELY

FEMALES ONLY

MALE & FEMALE

MED ALLERGY/REACTION

Pregnant? YES NO
 Planning Pregnancy? YES NO
 Menopausal? YES NO
 Date of last period? _____
 Date of last PAP _____
 Results? NORMAL ABNORMAL
 Date of Last Mammogram _____
 Results? NORMAL ABNORMAL
 # Of: Pregnancies ___ Abortions ___
 Miscarriage ___ Live Births ___

Date of last Colonoscopy? _____
 Results? NORMAL ABNORMAL
 Date of last flu shot? _____
 Date of last pneumonia shot? _____
 Date of last Tetanus shot? _____
 Date of last TB Skin test? _____
 Date of last rectal exam? _____
 Date of last testicular exam? _____
 Are you currently in pain? YES NO
 On a scale from 1-10 rate pain? _____

If more then attach list to back of form

MEDICATIONS: Include Vitamins

DOSAGE: Mg, Mcg, ML

TAKEN DAILY

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Patient Signature _____

Date _____