

TRAVERSE HEALTH CLINIC
PATIENT MEDICAL HISTORY FORM

Please Print

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

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: _____