SONSHINE Health FAMILY Clinic

Confidential Medical History Form

Name: _____ Date of Birth: _____

Allergies Have you ever had an allergic reaction? ☐ Yes ☐ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): _____

List all medications, vitamins, supplements (attach list if needed)

Medication	Dosage	How often

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

Please circle whether Mother, Father, Siblings or Grandparents have a history of the following:

Alcoholism Blood Clots/Clotting Disorders Breast Cancer Colon Cancer Melanoma
Other Cancers (List Type): _____
Diabetes Drug Dependency Heart Disease High Blood Pressure
High Cholesterol Mental Illness Stroke Sudden Cardiac Arrest (under age 50)
Other (Please explain): _____
Parent Deceased How did your parent die?_____

PAST/CURRENT PERSONAL MEDICAL HISTORY:

Have YOU EVER had any of the following?

Heart/Lungs: ☐ Asthma ☐ Heart Disease (valve, vessel, rheumatic, etc.) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia

Endocrine: ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder

Kidney: ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones

Ears/Eyes/Nose/Throat: ☐ Chronic Sinus Infections ☐ Eye Disorders (other than glasses or contacts) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever

Stomach/Bowel: ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease ☐ GERD

Neurological: ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA ☐ Loss of memory

Mental Health: ☐ ADHD ☐ Alcohol Abuse ☐ Anorexia (Eating Disorder) ☐ Anxiety Disorder ☐ Bulimia (Eating Disorder) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems

Hematology/Oncology: ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy

OB/GYN: ☐ Endometriosis ☐ Pregnancies #: _____ Other History ☐ When was your last menstrual period? _____ What are you using for birth control? _____

Orthopedics: ☐ Arthritis ☐ Fractures/Broken Bones

Infectious Diseases: ☐ Chickenpox/Varicella ☐ Hepatitis Type: _____ ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever

Skin: ☐ Eczema ☐ Psoriasis ☐ Hives

STDs: ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD

Surgical History: ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair L ___ R ___ ☐ Knee Arthroscopy L ___ R ___ ☐ Organ Transplant ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries Social History

Lifestyle: Do you drink alcohol? _____ Amount and how often: _____ Do you exercise regularly? _____
Do you take recreational drugs? _____ Do you smoke? _____ How much? _____
Do you use smokeless tobacco? _____ How much? Are you interested in help with quitting? _____
Do you have guns in your home? _____ If so, are they kept locked up so children cannot access them? _____
Date of last preventive exam: _____ Date of last pap smear: _____ Date of last mammogram: _____
Date of last colonoscopy: _____ Date of last bone density scan: _____ Date of last eye exam: _____
Date of last dental exam: _____
Do you feel safe at home? _____ Do you feel safe in your current intimate relationship? _____

When did you last have the following immunizations?

Influenza _____ Chicken pox _____ Hepatitis B _____ Hepatitis A _____ MMR _____ Polio _____ Pneumonia _____ Shingles _____ tetanus (tD, tDap) _____

Previous Hospitalizations: _____ _____

OTHER Health Problems: _____

What is the main reason you are here today?_____