5-Hole 1/4 1 3/8 c-to-c

BON SECOURS MEDICAL GROUP

Place patient label inside box (if no patient label, complete below)

Name: ______________________

DOB: ______________________

MR #: ______________________

MEDICAL HISTORY

Living Will? ☐ Yes ☐ No   Power of Attorney? ☐ Yes ☐ No

1. Do you have any allergies? ☐ Yes ☐ No
   If yes, Please specify medication and reaction: ______________________

2. Name any physician(s) currently attending you. ______________________

3. List any hospitalization(s) and/or surgeries you have had. ______________________

4. Immunizations/Tuberculosis
   If you have had the following, list year of most recent vaccination:
   Tetanus: __________ Flu: __________ Pneumovax: __________
   Hepatitis B: __________ Measles: __________ Rubella: __________
   If you have been previously skin tested for tuberculosis, year of test: __________
   Result: ☐ negative (no reaction) ☐ positive

5. **To be completed by women:** Do you currently take birth control pills? ☐ Yes ☐ No
   Last menstrual cycle started __________ and ended __________
   Average length of cycle? __________ days. Is your menstrual flow normal? ☐ Yes ☐ No
   Number of children __________ Number of pregnancies __________ Number of miscarriages __________

6. Check any of the following problems that apply to you.

☐ Acid indigestion or heartburn
☐ AIDS
☐ Anemia
☐ Asthma
☐ Back trouble
☐ Bad teeth or dentures
☐ Black bowel movements
☐ Blood in bowel movement
☐ Blurred vision
☐ Burning when urinating
☐ Change in weight
☐ Chest pain
☐ Cocaine or other drug use
☐ Cold hurts my fingers
☐ Constipation
☐ Coughing
☐ Coughing up blood
☐ Depression
☐ Diabetes
☐ Diarrhea
☐ Discomfort on moving bowels
☐ Dizziness
☐ Double Vision
☐ Ear aches
☐ Epilepsy or seizures
☐ Fainting spells
☐ Fast heart beat
☐ Frequency urinating
☐ Frequent headaches
☐ Frequent nosebleeds
☐ Gallbladder problems
☐ Gonorrhea
☐ Hair falling out
☐ Heart disease
☐ Heart Attack
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ High blood pressure
☐ Inflamed eyes
☐ Intestinal parasites
☐ Irregular heart beat
☐ Joint Pain
☐ Joint swelling
☐ Kidney disease/stones
☐ Kidney or bladder infection
☐ Malaria
☐ Muscle aches
☐ Muscle pain
☐ Muscle weakness
☐ Poor appetite
☐ Prostate problems
☐ Pus, albumin or sugar in urine
☐ Rheumatic Fever
☐ Rheumatism
☐ Shortness of breath
☐ Sinus problems
☐ Skin disease, frequent boils
☐ Sore throat
☐ Stiff joints
☐ Stomach pain
☐ Stress or anxiety
☐ Stroke
☐ Swallowing difficulty
☐ Syphilis
☐ Thyroid problems
☐ Tightness in chest
☐ Trouble controlling urine
☐ Trouble getting urine started
☐ Trouble sleeping
☐ Ulcers
☐ Vomiting or nausea
☐ Weakness of an arm or leg
☐ Weakness or tiredness
☐ Wheezing
☐ Yellow jaundice

7. Please list any immediate family members who have experienced the following:

Cancer & type:	☐ Yes	☐ No	Family Member?	
Diabetes:	☐ Yes	☐ No	Family Member?	
Heart disease:	☐ Yes	☐ No	Family Member?	
Mental illness:	☐ Yes	☐ No	Family Member?	
High blood pressure:	☐ Yes	☐ No	Family Member?	
Stroke:	☐ Yes	☐ No	Family Member?	
Any other serious illness:	☐ Yes	☐ No	Family Member?	

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SOCIAL HISTORY

Social History			
Marital Status	☐ Single	☐ Partnered	☐ Separated
	☐ Married	☐ Divorced	☐ Widowed
Living	☐ Live alone	☐ Live with significant other	
	☐ Live with spouse	☐ Live with other	
	Race: ______________	Ethnicity: ______________	
Employment	☐ Occupation/ Employer →		
	☐ Homemaker		
	☐ Student (where, major, year) →		

Tobacco			
Tobacco	☐ NO - I do not smoke and have never smoked		
	☐ YES - I previously smoked but no longer smoke	Quit Date?	
		Previous # of packs per day?	
	☐ YES - I am currently smoking	Previous # of yrs smoking?	
		Number of packs per day?	
		Number of years smoking?	
Alcohol	☐ NO - I do not drink any alcohol		
	☐ YES - I previously drank alcohol but no longer drink alcohol	Quit Date?	
		Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	
	☐ YES - I drink alcohol	Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	

Drugs			
Drugs	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
	What type of street drugs have you used in the past or are currently using?		
Sexual History	Are you sexually active?	☐ Yes	☐ No
	If yes, are you currently trying to become pregnant?	☐ Yes	☐ No
	If not trying to become pregnant, list contraceptive or barrier method using:		
	When was your last menstrual period? How many periods do you have per year?		
Military History	Have you ever been in the military service?	☐ Yes	☐ No
	If so, which branch? ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard ☐ Reserves ☐ Other		

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